

SERFF Tracking Number: ALST-126282608 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 43415
 Company Tracking Number: GVA WALMART
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Group Accident for Walmart
 Project Name/Number: /

Filing at a Glance

Company: American Heritage Life Insurance Company

Product Name: Group Accident for Walmart SERFF Tr Num: ALST-126282608 State: Arkansas
 TOI: H02G Group Health - Accident Only SERFF Status: Closed-Approved- State Tr Num: 43415
 Closed

Sub-TOI: H02G.000 Health - Accident Only Co Tr Num: GVA WALMART State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor
 Authors: Angie Redden, Jennifer Disposition Date: 09/16/2009
 Aiello, Lynn Bautista, Patti Hicks
 Date Submitted: 09/04/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Not Filed
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Group
 Submission Type: Resubmission Previous Filing Number: ALST-126250239
 Group Market Size: Large Overall Rate Impact:
 Group Market Type: Employer Filing Status Changed: 09/16/2009
 Explanation for Other Group Market Type:
 State Status Changed: 09/16/2009 Deemer Date:
 Created By: Lynn Bautista Submitted By: Lynn Bautista

Corresponding Filing Tracking Number:

Filing Description:

These forms are being submitted for your review and approval. These forms were previously approved by your department on August 6, 2009 under filing ALST-126250239. These forms are for a single case filing to provide group voluntary coverage as requested by Walmart Stores Inc., to provide benefits to their employees beginning January 1, 2010. Walmart's 2009 open enrollment for their 2010 benefits will begin in October of this year. The benefits and many of the administrative provisions have been designed and worded specifically at the request of the policyholder, Walmart.

Upon review of the policy and certificate, we found language that limited the benefits more than we intended. As such,

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we have removed or revised language to help clarify benefits to the policyholder and the insureds. A red-line version of both forms is provided for your convenience. These are the only changes to these forms.

Some formatting changes were made to the Evidence of Insurability forms AWD4528WM and AWD4528WMESP. Medical questions have not been changed.

All remaining forms associated with this policy have not had any changes since their last approval.

As this is a single case filing, for an employer incorporated in Arkansas, these forms have not been submitted to our domicile state.

Material may vary, but will always be in accordance with your state laws. Since these forms will be used to issue a Group Accident Insurance policy to Walmart Stores, Inc., the bracketing on these forms will allow us the ability to customize the form for this group. The original Statement of Variability, which remains unchanged since the last approval of the forms is included. Any logo, officer signature, or Home Office address and telephone number that appears on these forms is subject to change.

The enrollment may be taken through electronic enrollment procedures using the employer's benefit enrollment site using secure, valid electronic signature methodology.

As this filing is to replace our previous approved filing of these forms, we ask that filing ALST-126250239 be withdrawn.

If you have any questions, please let me know.

Company and Contact

Filing Contact Information

Lynn Bautista, Compliance Analyst CBautista@allstate.com
Attn: Legal/Compliance 904-992-3046 [Phone]
1776 American Heritage Life Drive 904-992-2975 [FAX]
Jacksonville, FL 32224-9983

Filing Company Information

American Heritage Life Insurance Company	CoCode: 60534	State of Domicile: Florida
ATTN: Legal/Compliance	Group Code: 8	Company Type: Life and Health
1776 American Heritage Life Drive	Group Name: Allstate	State ID Number:
Jacksonville, FL 32224-9983	FEIN Number: 59-0781901	
(904) 992-1776 ext. [Phone]		

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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: \$50 submitted per filing
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Heritage Life Insurance Company	\$50.00	09/04/2009	30349215

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/16/2009	09/16/2009
Approved-Closed	Rosalind Minor	09/09/2009	09/09/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Evidence of Insurability and Enrollment Form	Lynn Bautista	09/16/2009	09/16/2009
Form	Evidence of Insurability and Enrollment Form	Lynn Bautista	09/16/2009	09/16/2009

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Disposition

Disposition Date: 09/16/2009

Implementation Date:

Status: Approved-Closed

Comment:

This submission was reopened in order for you to make a revision to Forms AWD 4528WM & AWD 4528WMESP. I have reviewed these revised forms and they are being approved effective on this date.

The remainder of the filing will retain the original approval date.

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	General Amendment	Approved-Closed	Yes
Supporting Document	Red-line documents	Approved-Closed	Yes
Supporting Document	Variable Statement	Approved-Closed	Yes
Form	Group Accident Insurance Policy	Approved-Closed	Yes
Form	Group Accident Certificate of Insurance	Approved-Closed	Yes
Form (revised)	Evidence of Insurability and Enrollment Form		Yes
Form	Evidence of Insurability and Enrollment Form	Replaced	Yes
Form (revised)	Evidence of Insurability and Enrollment Form		Yes
Form	Evidence of Insurability and Enrollment Form	Replaced	Yes

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Amendment Letter

Submitted Date: 09/16/2009

Comments:

Forms AWD4528WM and AWD4528WMESP have been revised to add the following statement to page 2: "[If you elect child(ren) coverage, please list all children in the dependent section and answer the child(ren) medical questions if required based on all of your children, even if you have not enrolled them in other products.]" This is the only change to the form and was added at the request of the the policyholder, Walmart.

Thank you!

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
AWD4528WM	Application/Enrollment Form	Evidence of Insurability and Enrollment Form	Revised		ALST-126250239	AWD4528WM		Walmart Enrollment and EOI Form.pdf
AWD4528WMESP	Application/Enrollment Form	Evidence of Insurability and Enrollment Form	Revised		ALST-126250239	AWD4528WM		Walmart Enrollment and EOI Form Spanish.pdf

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Form Schedule

Lead Form Number: GAPWM

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/09/2009	GAPWM	Policy/Cont	Group Accident ract/Fratern Insurance Policy al Certificate	Revised	Replaced Form #: GAPWM Previous Filing #: ALST-126250239	51.300	GAPWM Policy.pdf
Approved-Closed 09/09/2009	GACWM	Certificate	Group Accident Certificate of Insurance	Revised	Replaced Form #: GACWM Previous Filing #: ALST-126250239	51.600	GACWM Certificate.pdf
	AWD4528 WM	Application/Enrollment Form	Evidence of Insurability and Enrollment Form	Revised	Replaced Form #: AWD4528WM Previous Filing #: ALST-126250239		Walmart Enrollment and EOI Form.pdf
	AWD4528 WMESP	Application/Enrollment Form	Evidence of Insurability and Enrollment Form	Revised	Replaced Form #: AWD4528WM Previous Filing #: ALST-126250239		Walmart Enrollment and EOI Form Spanish.pdf



[Workplace Division]

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
[1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776]

A Stock Company

1

GROUP ACCIDENT INSURANCE POLICY WHICH INCLUDES ACCIDENTAL DEATH AND DISMEMBERMENT NON-PARTICIPATING

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this policy carefully and contact us promptly with any questions. This policy is delivered in and is governed by the laws of the governing jurisdiction, and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

1. all policy provisions and any amendments and/or attachments issued; and
2. the policyholder's signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

2

[]

Secretary

[]

President

**THIS IS A GROUP ACCIDENT POLICY WHICH ONLY PROVIDES BENEFITS FOR
OFF-THE-JOB ACCIDENTS AS DEFINED AND ON- AND OFF-THE-JOB ACCIDENT
INTENSIVE CARE UNIT BENEFIT AS DEFINED WITHIN THIS POLICY
AND OTHER BENEFITS SPECIFICALLY DESCRIBED HEREIN.
THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**

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**GROUP ACCIDENT PLAN
WHICH INCLUDES ACCIDENTAL DEATH AND DISMEMBERMENT
POLICY SPECIFICATIONS**

- 4 **POLICYHOLDER:** [WALMART STORES, INC.]
- 5 **POLICY NUMBER:** [GROUP123]
- 6 **POLICY EFFECTIVE DATE:** [January 1, 2010]
- 7 **POLICY ANNIVERSARY DATE:** [January 1, 2011] and the [first day] of [January] each calendar year thereafter.
- GOVERNING JURISDICTION:** The state of Arkansas and subject to the laws of that jurisdiction.
- 8 **ELIGIBLE CLASS(ES):** [The classes of employees eligible for insurance are those classes defined in the policyholder's Health and Welfare Plan.]
- 9 **ELIGIBILITY WAITING PERIOD:** [The waiting period for eligible employees is as defined in the policyholder's Health and Welfare Plan]
- 10 **INITIAL RATE:** [Bi-weekly rate of \$XX.XX per employee for Employee-Only Coverage; or \$XX.XX per employee for Employee and Child(ren) Coverage; \$XX.XX per employee for Employee and Spouse Coverage; or \$XX.XX per employee for Family Coverage]
- 11 **RATE GUARANTEE DATE:** [12/31/2016 for active employees]
- 12 **PREMIUM DUE:** [01/01/2010 and bi-weekly thereafter.] The policyholder must send all premiums on or before the premium due date to us. The premium must be paid in United States dollars.
- 13 **COST OF COVERAGE:** [The employee pays the cost of coverage pre-tax through the policyholder's Flexible Benefit Plan.]
- 14 **[DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES**

These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

Name

Location (City and State)]

[None]

POLICYHOLDER PROVISIONS

RATE GUARANTEE

A change in premium rate will not take effect before the Rate Guarantee Date shown on page 3, except for the following reasons:

1. a change occurs in this plan design (including any material change in the eligibility rules) that is requested by the policyholder; or
- 15 2. the number of insured eligible employees decreases by [50%] or more due to corporate restructuring; or
3. a new law or a change in any existing law is enacted which applies to this policy that would materially change the cost of the policy.

We will notify the policyholder in writing at least [180 days] before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree in writing.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases may take effect any time subject to the "Rate Guarantee" provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

INFORMATION REQUIRED FROM THE POLICYHOLDER

The policyholder must provide us with the following on a regular basis:

1. information about employees:
 - a. who are eligible to become insured; and
 - b. whose coverage changes; and/or
 - c. whose coverage ends; and
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required to administer this policy.

CANCELING POLICY

This policy can be canceled:

1. by us; or
2. by the policyholder.

16 We may terminate or offer to modify this policy after the Rate Guarantee Date with at least [365 days] written notice to the policyholder, if:

1. the policyholder fails to perform any of its material obligations that relate to this policy; or
2. fewer than [50 employees] are insured.

With regards to the policyholder's failure to perform any of its material obligations that relate to this policy, before we give the policyholder [365 days] written notice of our intent to terminate or modify this policy, we must first give the policyholder [30 days] written notice of the breach and the opportunity to cure the breach during that [30 day] period. Only after giving such notice may we provide the policyholder with the [365 days] written notice of our intent to terminate or modify this policy.

The policyholder must pay us all premiums due for the full period this policy is in force. If the premium is not paid before the grace period ends, we may terminate this policy with at least [30 days] written notice to the policyholder. If the policyholder pays all past due premiums before the conclusion of the [30 day] notice period, the policy will not terminate.

The policyholder may cancel this policy by written notice delivered to us at least [180 days] prior to the cancellation date. When both the policyholder and we agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

GENERAL PROVISIONS

ELIGIBILITY OF DEPENDENTS

Eligible dependents are the individuals defined as "Eligible Dependents" under the policyholder's Health and Welfare Plan.

Dependents of an employee cannot be covered as both a dependent and as an employee with their own coverage. If a dependent is or becomes covered as an employee with their own coverage, we will terminate their coverage as a dependent and refund any premium that may have been paid for the dependent coverage for the period of time that they were covered as a dependent while having their own coverage.

A child born to the employee or spouse, while Employee and Child(ren) Coverage or Family Coverage is in force, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for other dependent children covered under this policy.

17 If the insured employee has Employee-Only Coverage [or Employee and Spouse Coverage], newborn children are automatically covered from the moment of birth for a period of [60 days]. If the insured employee desires uninterrupted coverage for a newborn child, the insured employee must notify the employer within [60 days] of that child's birth. Upon notification to us, we will convert the insured employee's Employee-Only Coverage to Employee and Child(ren) Coverage [or Employee and Spouse Coverage to Family Coverage] and provide notification of the additional premium due. If the insured employee does not notify the employer within [60 days] of the birth of the child, the temporary automatic coverage ends.

If the insured employee has Employee-Only Coverage or Employee and Child(ren) Coverage and marries and desires coverage for his or her spouse, the insured employee must notify the employer of the marriage within [60 days] of the marriage. We will convert the coverage to Employee and Spouse Coverage or Family Coverage and provide notification of the additional premium due.

An adopted child or child pending adoption will be covered as follows:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by the insured employee has been entered within [60 days] after the date of birth.
2. If adoption proceedings have been instituted by the insured employee within [60 days] after the date of birth and the insured employee has temporary custody, coverage is provided from the moment of birth.
3. For children other than newborns, if adoption proceedings have been completed, and a decree of adoption was entered within 1 year from the institution of the proceedings, coverage will begin upon temporary custody for 1 year, unless extended by the order of the court by reasons of the special needs of the child.

Coverage must be provided as long as the insured employee has custody of the child pursuant to decree of the court and required premiums are paid.

If the insured employee has Employee-Only Coverage [or Employee and Spouse Coverage], we will convert the Employee-Only Coverage to Employee and Child(ren) Coverage [or Employee and Spouse Coverage to Family Coverage] and provide notification of the additional premium due.

ELIGIBILITY DATE

If the employee is working for the policyholder in an eligible class, the date such employee is eligible for coverage is the later of:

1. the policy effective date; or
2. the date that the employee becomes eligible for coverage under the terms of the policyholder's Health and Welfare Plan.

WHEN AN ELIGIBLE EMPLOYEE CAN ENROLL FOR OR CHANGE COVERAGE

The employee may apply for or change coverage as permitted under the terms of the policyholder's Health and Welfare Plan.

GENERAL PROVISIONS (Continued)

EFFECTIVE DATE OF COVERAGE

Coverage for employees who enroll during the initial enrollment will be effective on the effective date of this policy. For employees who enroll subsequent to the effective date of this policy, coverage will be effective in accordance with the terms of the policyholder's Health and Welfare Plan.

For any change in an employee's coverage, the change in coverage is effective in accordance with the terms of the policyholder's Health and Welfare Plan.

CERTIFICATES OF INSURANCE

We will furnish to the policyholder a certificate of insurance for delivery to each insured employee. The certificate will provide a description of the insurance provided by this policy and will state:

1. the essential features of the insurance coverage; and
2. to whom benefits are payable.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

TERMINATION OF COVERAGE

The insured employee's coverage under this policy ends, subject to the "Portability Coverage" provision of this policy, on the earliest of:

1. the date this policy is canceled by the policyholder; or
2. the last day of the period for which such insured employee made any required premium payments; or
3. the last day such insured employee is in active employment, except as provided under the "Leave of Absence" provision; or
4. the date such insured employee is no longer in an eligible class; or
5. the date such insured employee's class is no longer eligible.

We will provide coverage for a payable claim that occurs while the insured employee is covered under this policy.

If the insured employee's spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or death of the insured employee, or when an insured employee moves to an eligible class that does not provide spouse coverage.

Coverage for a dependent child ends on the certificate anniversary next following the date the child is no longer eligible for coverage under the terms of the policyholder's Health and Welfare Plan. Coverage does not terminate for an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under this policy; and
3. is chiefly dependent upon the insured employee for support and maintenance.

The child's coverage continues as long as the insured employee's coverage remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished to us when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims incurred after termination will not be paid. There may be no refund due if the insured employee has Employee and Child(ren) Coverage or Family Coverage and there are other eligible dependents insured under this policy.

Coverage may be eligible for continuation as outlined in the "Portability Coverage" provision.

AGENCY

For purposes of this policy, the policyholder acts on its own behalf or as the employee's agent. Under no circumstances will the policyholder be deemed our agent.

GENERAL PROVISIONS (Continued)

LEAVE OF ABSENCE

If an insured employee ceases active employment because of a leave of absence while coverage is in force, he or she will have the opportunity to continue coverage while he or she is away from active employment. Coverage will be in accordance with the terms of the policyholder's Health and Welfare Plan. This includes, but is not limited to, how coverage is provided, how premiums are paid for during the absence, and whether coverage is reinstated upon return to employment.

GRACE PERIOD

18

The policyholder is entitled to a grace period of [60 days] for the payment of any premium due. This policy continues in force during the grace period, unless the policyholder gives us written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of this policy. The policyholder is liable to us for the payment of any pro-rata premium for the time this policy is in force during a grace period.

ENTIRE CONTRACT

The contract consists of the following items:

1. the group policy; and
2. any amendments and endorsements; and
3. the application and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the insured employee.

Any statements made by the policyholder or by a covered person, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or the covered person will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his or her beneficiary, if any, if a claim is denied based upon such a statement.

INCONTESTABILITY

After 2 years from the effective date of this policy, no misstatement of the policyholder, made in any applications, can be used to void this policy. After 2 years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim.

19 [DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of this policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of this policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of this policy, such determinations shall be final and conclusive.]

LEGAL ACTION

No legal action may be brought to obtain benefits under this policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 180 days from the time a decision on appeal regarding a claim for benefits under this policy has been rendered. A lawsuit may not be filed after this 180 day period expires.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder documenting any clerical errors.

GENERAL PROVISIONS (Continued)

BENEFICIARY; CHANGE OF BENEFICIARY

If there is no named beneficiary, we will pay any benefits due at a covered person's death in the following order:

- 20
1. [to the insured employee, if living; otherwise
 2. to the insured employee's spouse, if living; otherwise
 3. to the covered person's children, in equal shares, if living; otherwise
 4. to the covered person's parents, in equal shares, if living; otherwise
 5. to the covered person's siblings, in equal shares, if living; otherwise
 6. to the covered person's estate].

Any change of beneficiary must be filed with the policyholder or at our home office. It will not take effect unless so filed, but if so filed, will take effect on the date signed. This will be true whether or not the covered person is living on the date it is filed. There will be no prejudice to us on account of any payment we make prior to its receipt by us at our home office.

21 [UNPAID PREMIUM; EXCESS PREMIUM

Upon the payment of a claim under this policy, any premium owed by an employee in an individual capacity that is more than [60 days] past due may be deducted from the benefit amount payable to the employee. Any excess premium will be refunded to the employee.]

(This space intentionally left blank.)

PORTABILITY COVERAGE

We will provide portability coverage, subject to these provisions.

Such coverage will be available for a covered person, if the following criteria are satisfied:

1. coverage under this policy terminates as described in the General Provision entitled "Termination of Coverage"; and
2. we receive a request for portability and payment of the first premium for the portability coverage not later than [60 days] after such termination.

No portability coverage will be provided for any person, if his or her insurance under this policy terminated due to his or her failure to make required premium payments.

PORTABILITY COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under this policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under this policy. Any change made to this policy after a covered person is insured under the portability coverage will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after a covered person's coverage under this policy terminates.

PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance of each month of coverage to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate for the first [36 months] of portability coverage is the rate in effect under this policy for active employees who have the same coverage. After the first [36 months], the premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least [31 days] before any change is to take effect.

GRACE PERIOD

The grace period, as defined in this policy, will apply to each certificate holder of portability coverage as if such covered person is the policyholder.

TERMINATION OF PORTABILITY COVERAGE

Insurance under this portability coverage will automatically end on the earliest of the following dates:

1. the date the person again becomes eligible for insurance under this policy; or
2. the last day for which premiums have been paid, if the covered person fails to pay premiums when due, subject to the grace period; or
3. with respect to insurance for dependents:
 - a. the date the employee's insurance terminates; or
 - b. the date the dependent ceases to be an eligible dependent, as defined.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

TERMINATION OF THE POLICY

If this policy terminates, insured employees and their covered dependents will be eligible to exercise the portability privilege on the termination date of this policy. Portability coverage may continue beyond the termination date of this policy, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if this policy had remained in full force and effect.

LIMITATIONS AND EXCLUSIONS

This policy does not cover any loss incurred by a covered person as a result of:

1. an injury that occurred as the result of an on-the-job accident, except as may be provided under the On- and Off-the-Job Accident Only Intensive Care Unit Benefit; or
2. injury incurred prior to the covered person's effective date of coverage subject to the Incontestability provision; or
3. any act of war whether or not declared, participation in a riot, insurrection or rebellion; or
4. suicide, or any attempt at suicide, whether sane or insane; or
5. any injury sustained while the covered person is under the influence of alcohol or any narcotic, unless administered upon the advice of a physician; or
6. dental or plastic surgery for cosmetic purposes except when such surgery is required to treat an injury or correct a disorder of normal bodily function that was caused by an injury; or
7. participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or
8. committing or attempting to commit an assault or felony; or
9. driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway.

Any injury incurred while a covered person is an active member of the Military; Naval; or Air Forces of any country or combination of countries is not covered. Upon notice and proof of service in such forces, we will return the pro-rata portion of the premium paid for any period of such service.

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BENEFIT INFORMATION

OFF-THE-JOB ACCIDENT ONLY BENEFITS

If, while this policy is in force, a covered person sustains an injury caused by an off-the-job accident which results in any of the losses stated in this "Benefit Information" provision, and is diagnosed by a physician, we pay the following benefits for such loss. Any loss not stated in this "Benefit Information" provision is not covered under this policy.

- A. Emergency Treatment:** We pay \$120 for the insured employee or covered spouse and \$70 for a covered child for required medical treatment as a result of a covered accident. This benefit is payable for physician fees, x-rays, and emergency room services. Treatment must be received within 72 hours of the covered accident. This benefit is payable only once for any and all treatment that occurs during any 24-hour period, per covered person, per covered accident.
- B. Follow-Up Treatment:** We pay \$25 per follow-up visit when a covered person requires additional follow-up treatment after receiving emergency treatment for which a benefit is paid under Emergency Treatment (benefit A). Follow-up treatment must be administered by a physician in a physician's office or in a hospital on an outpatient basis. Follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital. This benefit is payable for 1 follow-up treatment per day for a maximum of 6 treatments, per covered person, per covered accident. This benefit is not payable for treatments for which the Physical Therapy benefit (benefit R) is paid.
- C. Initial Hospitalization:** We pay \$1,000 the first time a covered person is hospital confined for at least 24 hours for treatment as a result of an injury; or \$1,500 if the covered person is admitted directly to a hospital intensive care unit. Confinement must start within 30 days of the covered accident. This benefit is payable only once per continuous hospital or intensive care unit confinement, per calendar year, per covered person.
- D. Hospital Confinement:** We pay a daily benefit of \$200 for a continuous hospital confinement, up to 365 days per covered accident, when a covered person is hospital confined for at least 18 hours for treatment as a result of an injury. Confinement must start within 30 days of the covered accident. This benefit is not payable for days on which the Rehabilitation benefit (benefit S) is paid. This benefit is paid in addition to the Initial Hospitalization benefit (benefit C).
- E. Intensive Care Unit Confinement:** We pay a daily benefit of \$400, up to 15 days for any 1 accident, per covered person, when a covered person is confined in a hospital intensive care unit, as a result of an injury. This benefit is paid in addition to the Initial Hospitalization benefit (benefit C) and the Hospital Confinement benefit (benefit D). Confinement must start within 30 days of the covered accident.
- F. Dislocation:** We pay the benefit amount shown in the chart below when a covered person sustains a dislocation as a result of a covered accident. This benefit is payable for only the first dislocation of a joint. If a covered dislocation is reduced with local anesthesia or no anesthesia by a physician, we will pay 25% of the benefit amount shown in the chart below. This benefit is payable for a maximum of 2 covered dislocations per covered person, per covered accident. If more than 2 dislocations occur during a covered accident, we will pay benefits for the 2 dislocations with the largest dollar amount benefits.

<u>Joint</u>	<u>Benefit Amount</u>
Hip	\$2,000
Collar bone	\$800
Knee or shoulder	\$500
Ankle or foot (excluding toes)	\$500
Lower jaw	\$500
Wrist or elbow	\$400
Toe or finger	\$100

BENEFIT INFORMATION (Continued)

OFF-THE-JOB ACCIDENT ONLY BENEFITS (Continued)

- G. Burns:** We pay the benefit amount shown in the chart below when a covered person sustains a burn as a result of an accident if treated by a physician within 72 hours after a covered accident. Injuries due to sunburn are not a covered benefit.

<u>Affected Area</u>	<u>Benefit Amount</u>	
	<u>2nd Degree</u>	<u>3rd Degree</u>
1 through 19 square centimeters of the body surface	\$100	\$200
20 through 39 square centimeters of the body surface	\$200	\$500
More than 40 but less than 65 square centimeters of the body surface	\$400	\$1,000
More than 65 but less than 160 square centimeters of the body surface	\$600	\$3,000
More than 160 but less than 225 square centimeters of the body surface	\$800	\$7,000
More than 225 square centimeters of the body surface	\$1,000	\$10,000

If the proof of loss does not specify the size of the burn, the lowest benefit amount shown will be paid.

- H. Skin Grafts:** We pay 50% of the benefit amount paid under the Burns benefit (benefit G) if a covered person receives 1 or more skin grafts for a covered burn. This benefit is paid in addition to the Burns benefit (benefit G).

- I. Eye Injury:** We pay \$250 for surgical repair or \$50 for removal of a foreign body by a physician if a covered person sustains an eye injury as a result of a covered accident.

- J. Lacerations:** We pay the benefit amount shown in the chart below when a covered person receives treatment for lacerations within 72 hours after a covered accident.

<u>Laceration</u>	<u>Benefit Amount</u>
Laceration(s) not requiring sutures	\$25
Single laceration less than 5 centimeters	\$50
Laceration(s) at least 5 centimeters but not more than 15 centimeters (total of all lacerations)	\$200
Laceration(s) over 15 centimeters (total of all lacerations)	\$400

If the proof of loss does not specify the size of the laceration, the lowest benefit amount shown will be paid.

- K. Fractures:** We pay the benefit amount shown in the chart below when a covered person sustains a fracture corrected by open or closed repair as a result of a covered accident. This benefit is payable for no more than 2 fractures per covered person, per covered accident. If more than 2 fractures occur during a covered accident, we will pay benefits for the 2 fractures with the largest dollar amount benefits.

<u>Fracture</u>	<u>Benefit Amount</u>
Hip	\$2,000
Skull	
depressed	\$1,500
simple	\$500
Leg	\$1,000
Rib	\$1,000
Vertebrae (body of), pelvis (excluding coccyx), or sternum	\$1,000
Vertebral processes	\$1,000
Upper jaw, upper arm, or face (excluding nose)	\$600
Hand (excluding fingers)	\$500
Foot (excluding toes/heel)	\$500
Lower jaw	\$500
Nose, heel, or finger	\$500
Shoulder blade or forearm	\$500
Wrist, elbow, ankle, or kneecap	\$500
Coccyx	\$200
Toe	\$200

We pay 25% of the amounts shown for chip fractures or other fractures not corrected by open or closed repair.

BENEFIT INFORMATION (Continued)

OFF-THE-JOB ACCIDENT ONLY BENEFITS (Continued)

- L. Emergency Dental Services:** We pay the benefit amount shown in the chart below when a covered person receives dental services as a result of an injury. This benefit is payable for no more than 1 dental benefit per covered person, per covered accident.

<u>Dental Service</u>	<u>Benefit Amount</u>
Broken teeth repaired with crowns	\$150
Broken teeth resulting in extractions	\$50

- M. Coma:** We pay \$10,000 if a covered person is in a coma as a result of a covered accident.

- N. Brain Concussion:** We pay \$50 if a covered person sustains a concussion as a result of a covered accident.

- O. Paralysis:** We pay the benefit amount shown in the chart below if a covered person suffers from spinal cord injury received in a covered accident which results in a complete and total loss of use of 2 or more limbs. Paralysis must last 30 or more consecutive days and must be confirmed by a physician. This benefit is only payable once per covered person.

<u>Paralysis</u>	<u>Benefit Amount</u>
Quadriplegia (Paralysis of 4 limbs)	\$10,000
Paraplegia (Paralysis of 2 limbs)	\$5,000

- P. Surgical Procedures:** We pay the benefit amount shown in the chart below if a covered person requires a surgical procedure as a result of a covered accident. Two or more surgical procedures performed through the same incision or entry point are considered 1 operation; we pay the amount for the procedure with the largest dollar amount benefit. Surgery must be performed within 1 year of a covered accident. Miscellaneous surgery is surgery that requires general anesthesia and is not covered by any other specific surgery benefit listed below. The miscellaneous surgery benefit is payable only once per 24 hour period even though more than 1 surgery or procedure may be performed.

<u>Surgery</u>	<u>Benefit Amount</u>
Open abdominal (including exploratory laparotomy), cranial, hernia, or thoracic surgery	\$1,000
Ruptured discs	\$500
Tendons and/or ligaments	\$500
Torn knee cartilages	\$500
Torn rotator cuffs	\$500
Arthroscopy without surgical repair	\$250
Miscellaneous surgery	\$250

- Q. Major Diagnostic Exams:** We pay \$150 if a covered person requires 1 of the following exams as a result of a covered injury: CT (computerized tomography) scan; MRI (magnetic resonance imaging); or EEG (electroencephalogram). The exam must be performed in a hospital, a physician's office, or an ambulatory surgical center. This benefit is limited to 1 payment per calendar year, per covered person.

- R. Physical Therapy:** We pay \$25 per day for physical therapy if a covered person receives physical therapy as a result of a covered injury. Therapy must be prescribed by a physician and begin within 30 days of the covered accident or discharge from the hospital and be received within the first 6 months after the covered accident or discharge from the hospital. This benefit is payable for 1 treatment per day for a maximum of 10 treatments per covered accident, per covered person. This benefit is not payable for treatments which the Follow-Up Treatment benefit (benefit B) is paid.

- S. Rehabilitation:** We pay \$100 per day if a covered person is confined to a rehabilitation unit as a result of a covered accident, provided that the covered person has been confined to a hospital immediately prior to being transferred to the rehabilitation unit. This benefit is paid for each day a room charge is incurred, up to 30 days for each covered person per continuous period of rehabilitation unit confinement, for a maximum of 60 days per calendar year. This benefit is not payable for days in which the Hospital Confinement benefit (benefit D) is paid.

BENEFIT INFORMATION (Continued)

OFF-THE-JOB ACCIDENT ONLY BENEFITS (Continued)

- T. Appliances:** We pay \$100 if a covered person, as a result of a covered injury and upon the advice of a physician, requires the use of a medical appliance as an aid in personal locomotion or mobility. Covered medical appliances are: crutches; wheelchair; leg brace; back brace; and walker. This benefit is payable only once per covered person, per covered accident.
- U. Prosthesis:** We pay \$500 if a covered person requires a prosthetic device as a result of a covered injury. This benefit is not payable for hearing aids, wigs, or any dental aids including false teeth. This benefit is payable only once per covered person, per covered accident.
- V. Blood, Plasma and/or Platelets:** We pay \$100 if a covered person, as a result of a covered injury, requires blood, plasma, and/or platelets. This benefit is not payable for immunoglobulins and is payable only once per covered person, per covered accident.
- W. Ambulance:** We pay \$150 for ground ambulance or \$1,000 for air ambulance if a covered person requires ambulance transportation to a hospital or emergency center as a result of a covered injury. The ambulance transportation must occur within 72 hours of the covered accident. Service must be provided by a licensed professional ambulance company.
- X. Transportation:** We pay \$400 per round trip for treatment at a non-local hospital as the result of a covered accident. This benefit is payable for only the covered person for whom the treatment is prescribed, except that if the treatment is for a covered dependent child and travel by common carrier is necessary, we pay an additional \$400 per round trip for 1 of the dependent child's parents or legal guardians to travel with the child. A physician must prescribe the treatment. This benefit is payable for up to 3 round trips per calendar year, per covered person. This benefit is not payable for transportation by ambulance or air ambulance to the hospital.
- Y. Family Lodging:** We pay \$100 per night for 1 motel/hotel room for an immediate family member to accompany the covered person who requires non-local hospital confinement as a result of a covered accident. This benefit is payable for up to 30 days per covered accident, and only during the days the covered person is confined in the hospital.
- Z. Accidental Death and Dismemberment:** We pay the benefit amount shown in the chart below if death or dismemberment occurs as a result of an injury sustained in a covered accident within 90 days of such accident. If more than 1 dismemberment is sustained in any 1 accident, the total amount we will pay will not exceed the highest single benefit for accidental dismemberment. Benefits are payable only once for any covered accident. If death and dismemberment result from the same accident, only the Accidental Death benefit will be paid. This benefit is paid regardless of whether the dismembered body part is surgically reattached.

<u>Accidental Death</u>	<u>Common Carrier</u>	<u>Other Accidents</u>			
Insured Employee:	\$100,000	\$25,000			
Covered Spouse:	\$100,000	\$25,000			
Covered Child:	\$15,000	\$7,500			
<u>Accidental Dismemberment</u>	<u>Both arms and both legs</u>	<u>2 eyes, feet, hands, arms or legs</u>	<u>1 eye, foot, hand, arm or leg</u>	<u>1 or more fingers and/or 1 or more toes</u>	
Insured Employee:	\$25,000	\$25,000	\$6,250	\$1,250	
Covered Spouse:	\$25,000	\$25,000	\$6,250	\$1,250	
Covered Child:	\$7,500	\$7,500	\$1,875	\$500	

BENEFIT INFORMATION (Continued)

ON- AND OFF-THE-JOB ACCIDENT ONLY INTENSIVE CARE UNIT BENEFIT

- A. Intensive Care Unit:** We pay a daily benefit of \$600 when a covered person is confined to an intensive care unit for at least 18 hours as a result of an injury from a covered on-the-job accident. This benefit is payable for up to 15 days per covered person, per covered accident. Confinement must start within 30 days of the accident.
- B. Step-down Intensive Care Unit Confinement:** We pay a daily benefit of \$200 for an off-the-job accident or \$400 for an on-the-job accident when a covered person is confined to a step-down intensive care unit for at least 18 hours as a result of an injury sustained from a covered accident. This benefit is payable in addition to any Hospital Confinement benefit (benefit D) payable for a covered accident. This benefit is payable for up to 15 days per covered person, per covered accident.

WELLNESS BENEFIT

23 Wellness: We pay [\$75] per certificate year, for either the insured employee or 1 other covered person, when an eligible examination or test is performed, after the insured employee's coverage has been in force for at least 12 months. The test must be performed under the supervision of or recommended by a physician, while coverage is in force, and a charge must be incurred. We will pay this benefit regardless of the result of the examination or test. The eligible wellness examinations and tests are:

1. [annual physical examination; and
2. dental examination; and
3. mammography; and
4. pap smear; and
5. eye examination; and
6. immunization; and
7. flexible sigmoidoscopy; and
8. PSA (prostate specific antigen – blood test for prostate cancer); and
9. ultrasound; and
10. blood screening].

[If the employee was insured by the prior accident policy offered through the policyholder's Health and Welfare Plan, the length of time his or her coverage was in effect will reduce the waiting period for receiving benefits under this wellness benefit.]

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CLAIM INFORMATION

NOTICE OF CLAIM

24 We encourage a covered person to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim must be given to us within 60 days after the occurrence or commencement of any loss covered by this policy, or as soon as reasonably possible. Notice given to us by, or on behalf of, a covered person or the beneficiary to us at [PO Box 41488, Jacksonville FL 32203-1488], with the covered person's name and certificate number, is notice to us.

A claim form can be requested from us. If it is not received within 15 days of the request, notice of claim may be sent to us by providing us a statement of the nature and extent of the loss.

FILING A CLAIM

25 [If a covered person's claim is denied, a notice will be sent within a reasonable time period, but not longer than 90 days from receipt of the claim. If we determine that an extension is necessary due to special circumstances, this time may be extended for an additional 90 days. A covered person will receive notice before the extension that indicates the special circumstances requiring the extension and the date by which we expect to render a determination.

If the claim is in part or wholly denied, the covered person will receive notice of an adverse benefit determination that will:

- state the specific reason(s) for the adverse benefit determination; and
- reference the specific policy provisions on which the determination is based; and
- describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary; and
- describe the policy's claims review procedures and the time limits applicable to such procedures, including a statement of the covered person's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.]

PROOF OF CLAIM

Written proof must be given to us within 90 days of each loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 15 months from the time specified unless the covered person is legally incapacitated.

COOPERATION OF BENEFICIARY

The beneficiary must reasonably cooperate during any investigation and/or adjudication of a claim. This includes the authorization for the release of medical records and other information.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have any covered person examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of contestability, where it is not forbidden by law.

PAYMENT OF CLAIMS

After receiving written proof of loss, we will pay all benefits then due under this policy and will make payment to the insured employee, unless the insured employee assigned the benefit to someone else. Any amounts unpaid at the insured employee's death may, at our option, be paid either to the named beneficiary or as described in the "Beneficiary; Change of Beneficiary" provision.

ASSIGNMENT

An assignment of the coverage under this policy is not binding on us, unless:

1. it is a written request; and
2. it is received and recorded by us at our home office.

We are not responsible for the validity of any assignment. An assignment is subject to any payment we make or other action we take before we record the assignment. An assignment may not change the owner or beneficiary.

CLAIM INFORMATION (Continued)

OVERPAID CLAIM

We have the right to recover any overpayments due to:

1. fraud; or
2. any error we make in processing a claim.

The insured employee must reimburse us in full. We will work with such insured employee to develop a reasonable method of repayment if he or she is financially unable to repay us in a lump sum.

We will not recover more money than we overpaid.

CLAIM REVIEW

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[A covered person will have 60 days from the receipt of an adverse benefit determination to file an appeal. Requests for appeals should be sent to [Allstate Workplace Division, Wal-Mart Claims Unit, PO Box 41488, Jacksonville FL 32203-1488], Attention: Appeals.

A covered person will have the opportunity to submit written comments, documents, or other information in support of the appeal, and the covered person will have access to all documents that are relevant to the claim.

The covered person will be notified of our benefit determination on review within a reasonable time, but not later than 60 days from receipt of the request for review. If we determine that an extension is necessary due to special circumstances, this time may be extended for an additional 60 days. The covered person will receive notice before the extension that indicates the special circumstances requiring the extension and the date by which we expect to render a determination.

If the claim is in part or wholly denied, the covered person will receive notice of an adverse benefit determination that will:

- state specific reason(s) of the adverse determination;
- reference specific policy provision(s) on which the benefit determination is based;
- state that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- describe any voluntary appeal procedures offered by the policy and the covered person's right to obtain information about such procedures; and
- include a statement regarding the covered person's right to bring an action under section 502(a) of ERISA.]

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GLOSSARY

Active Employment. Means that the employee is working for the employer for earnings that are paid regularly and is performing the material and substantial duties as assigned by the employer. The employee will be deemed to be in active employment on a day which is not one of the employer's scheduled work days only if actively employed on the preceding scheduled work day. Temporary and seasonal workers are excluded from coverage.

The location at which the employee performs work must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the job requires such employee to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment.

Calendar Year. Means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

Certificate Year. Means a consecutive 12 month period beginning on the effective date of insurance for each insured employee.

Coma. Means a continuous state of profound unconsciousness which lasts 7 or more consecutive days as a result of a covered accident. A coma is characterized by an absence of spontaneous eye movements, response to painful stimuli and vocalization. The condition must require intubation for respiratory assistance. Medically induced comas are excluded.

Common Carrier. Means only the following: commercial airlines; passenger trains; inter-city buslines; trolleys; or boats. It does not include taxis; intra-city buslines or private charter planes.

Continuous Hospital Confinement. Means 1 continuous confinement or 2 or more hospital confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Covered Accident. Means a sudden, unforeseen and unexpected event which occurs without the covered person's intent, which results in an injury to the covered person and for which benefits are payable.

Covered Person. Means any of the following:

1. any eligible family member (including the employee) named in the enrollment or evidence of insurability form and acceptable for coverage by us; or
2. any eligible dependent added after the effective date; or
3. a newborn child or adopted child subject to the "Eligibility of Dependents" provision.

Day. A 24 hour period.

Eligibility Waiting Period. Means the continuous period of time that the employee must be in active employment in an eligible class before he or she is eligible for coverage.

Employee. Means a person who is: (1) a citizen or resident of the United States or one of its territories; and (2) in active employment with the employer named as the policyholder.

Employee and Child(ren) Coverage. Means coverage that includes only the insured employee, as defined, and eligible children.

[Employee and Spouse Coverage. Means coverage that includes only the insured employee, as defined, and his or her spouse.]

Employee-Only Coverage. Means coverage that includes only the insured employee, as defined.

GLOSSARY (Continued)

Employer. Means the individual, company or corporation where the employee is in active employment, and includes any division, subsidiary, or affiliated company named in this policy.

Family Coverage. Means coverage that includes the insured employee, as defined, and his or her eligible dependents.

Fracture. Means a break in a bone that can be seen by x-ray and can be corrected by open (surgical) or closed (manipulative) repair.

27 **Grace Period.** Means a period of [60 days] following the premium due date during which premium payment may be made. While the insured employee is employed with the policyholder, the premiums will be paid by the policyholder through payroll deductions. The grace period only applies to the insured employee during any portability period, when the insured employee will be required to pay the premiums directly to us.

Hospital. Means a legally operated institution with established facilities (either on its premises or available to the hospital on a contractual, pre-arranged basis and under the supervision of a staff of 1 or more duly licensed physicians), for the care and treatment of sick and injured persons for diagnosis, surgery, and 24 hour nursing service. Hospital does not include:

1. any institution which is mainly a rest home, nursing home, convalescent home, or home for the aged; or
2. any institution which is mainly for the care and treatment of alcoholics or drug addicts, or mental or nervous disorders.

Hospital Confined or Confinement. Means confinement as an inpatient in a hospital for which a room and board charge is made by the hospital. It does not include confinement for an observation room or a fractional part of a day.

Hospital Intensive Care Unit. Means a hospital area of special care, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds, or wards normally used for patient confinement. In addition, the unit must provide the following:

1. 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis; and
2. direction and/or supervision by a full-time physician director or a standing "intensive care" committee of the medical staff; and
3. special medical apparatus used to treat the critically ill.

Hospital Intensive Care Unit Confinement. Means 1 continuous confinement or 2 or more hospital intensive care unit confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Immediate Family Member. Means spouse, mother, father, child, step-child, adopted child.

Injury. Means a bodily injury caused directly by an accident, independent of sickness, disease, bodily infirmity, or any other cause, occurring on or after the effective date of coverage and while coverage is in force. See the Limitations and Exclusions section for injuries not covered by this policy.

Inpatient. Means a covered person who is a resident patient using the room and board facilities of a hospital.

Insured Employee. Means an employee who has: (1) fulfilled all eligibility requirements set forth in this policy and the policyholder's Health and Welfare Plan; and (2) properly completed and signed the enrollment, provided that the enrollment has been received by us.

Leave of Absence. Means the employee is absent from active employment for a period of time that has been agreed to in advance in writing by the current employer.

Normal vacation time or any period of disability is not considered a leave of absence.

Non-local. Means more than 100 miles from the covered person's home or site of the accident.

GLOSSARY (Continued)

Nurse. Means any one of the following who is not a member of the covered person's immediate family or employed by the hospital where the covered person is confined:

1. licensed practical nurse (L.P.N.); or
2. licensed vocational nurse (L.V.N.); or
3. graduate registered nurse (R.N.).

Off-the-Job Accident. Means an accident that occurs while a covered person is not working at any job for pay or benefits.

On-the-Job Accident. Means an accident that occurs while a covered person is working at any job for pay or benefits.

Paralysis. Means spinal cord injuries received in a covered accident that result in complete and permanent loss of function of 2 or more limbs for a period of not less than 30 days. Paralysis must be confirmed by the attending physician.

Payable Claim. Means a claim for which we are liable under the terms of this policy.

Physician. Means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the state he or she practices in.

We will not recognize the insured employee, his or her spouse, children, parents, or siblings as a physician for a claim.

Policyholder. Means the legal entity to whom this policy is issued.

Rehabilitation Unit. Means a hospital area providing coordinated multi-disciplinary physical restorative services to inpatients under the direction of a physician who is knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

Step-down Intensive Care Unit. Means a hospital area of special care, which provides a level of medical care below the highest level of acute medical care available at the hospital, but above the level of medical care in a regular private or semiprivate room or ward. The facility is separate and apart from the surgical recovery room, other rooms, beds, or wards normally used for patient confinement. In addition, the unit must provide 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis.

Under the Influence. Means a condition as determined by the laws of the state in which the loss occurred.

We, Us and Our. Means American Heritage Life Insurance Company.

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Allstate[®]

Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224-6687

(904) 992-1776

A Stock Company

**THIS IS A GROUP ACCIDENT POLICY WHICH ONLY PROVIDES BENEFITS FOR
OFF-THE-JOB ACCIDENTS AS DEFINED AND ON- AND OFF-THE-JOB ACCIDENT
INTENSIVE CARE UNIT BENEFIT AS DEFINED WITHIN THIS POLICY
AND OTHER BENEFITS SPECIFICALLY DESCRIBED HEREIN.
THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**



[Workplace Division]

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
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JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776]

A Stock Company

1

(called "we", "our", "us" or "Company")

CERTIFICATE OF INSURANCE

This certificate explains the policy of insurance underwritten by us. It is not the contract of insurance. The policy (called the "policy"), as issued to the policyholder by us, alone makes up the agreement under which insurance coverage is provided and benefits are determined. The policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. The policy may be inspected at the office of the policyholder during normal business hours.

The accident coverage under this policy is a benefit offered as part of the Associates' Health and Welfare Plan (Plan). The Plan is an employer-sponsored health and welfare employee benefit plan governed under ERISA.

This document, together with the current version of the Associate Benefits Book, constitutes the summary plan description (SPD) for the accident coverage portion of the Plan. The SPD, together with the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan Wrap Document, are the Plan documents for the Plan.

As a summary, this SPD does not describe every provision of the controlling Plan, nor does it modify any provision of the applicable Plan documents.

CONSIDERATION

Your coverage under the policy is issued to you in consideration of your enrollment form or other form of application and the payment of the first premium. Your coverage under the policy is effective from 12:01 a.m. Standard Time on your effective date.

INSURING CLAUSE

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due. All such coverage is subject to the terms of the policy.

In this certificate the insured certificate holder (associate) will be referred to as "you", "your" or "yours".

This certificate supersedes and replaces any certificate previously issued to you under the policy.

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[]

Secretary

[]

President

THIS IS A GROUP ACCIDENT CERTIFICATE WHICH ONLY PROVIDES BENEFITS FOR OFF-THE-JOB ACCIDENTS AS DEFINED AND ON- AND OFF-THE-JOB ACCIDENT INTENSIVE CARE UNIT BENEFIT AS DEFINED WITHIN THIS CERTIFICATE AND OTHER BENEFITS SPECIFICALLY DESCRIBED HEREIN. THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

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GENERAL PROVISIONS

COVERAGE SUBJECT TO POLICY

The coverage described in this certificate is subject in every way to the terms of the policy that is issued to the policyholder. It alone makes up the agreement by which the insurance is provided. The group policy may be amended or discontinued by agreement between us and the policyholder in accordance with the terms of the policy. Your consent is not required for this. Neither are we required to give you prior notice.

ELIGIBILITY OF DEPENDENTS

Eligible dependents are the individuals defined as "Eligible Dependents" under the policyholder's Health and Welfare Plan.

Your dependents cannot be covered as both a dependent and as an associate with their own coverage. If your dependent is or becomes covered as an associate with their own coverage, we will terminate their coverage as a dependent and refund any premium that may have been paid for the dependent coverage for the period of time that they were covered as a dependent while having their own coverage.

A child born to you or your spouse, while Associate and Child(ren) Coverage or Family Coverage is in force, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for other dependent children covered under this certificate.

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If you have Associate-Only Coverage [or Associate and Spouse Coverage], newborn children are automatically covered from the moment of birth for a period of [60 days]. If you desire uninterrupted coverage for a newborn child, you must notify your employer within [60 days] of that child's birth. Upon notification to us, we will convert your Associate-Only Coverage to Associate and Child(ren) Coverage [or Associate and Spouse Coverage to Family Coverage] and provide notification of the additional premium due. If you do not notify your employer within [60 days] of the birth of the child, the temporary automatic coverage ends.

If you have Associate-Only Coverage or Associate and Child(ren) Coverage, then marry and desire coverage for your spouse, your employer must be notified within [60 days] of your marriage. We will convert your coverage to Associate and Spouse Coverage or Family Coverage and provide notification of the additional premium due.

An adopted child or child pending adoption will be covered as follows:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption has been entered into by you within [60 days] after the date of birth.
2. If adoption proceedings have been instituted by you within [60 days] after the date of birth and you have temporary custody, coverage is provided from the moment of birth.
3. For children other than newborns, if adoption proceedings have been completed, and a decree of adoption was entered within 1 year from the institution of the proceedings, coverage will begin upon temporary custody for 1 year, unless extended by the order of the court by reasons of the special needs of the child.

Coverage must be provided as long as you have custody of the child pursuant to decree of the court and required premiums are paid.

If you have Associate-Only Coverage [or Associate and Spouse Coverage], we will convert your Associate-Only Coverage to Associate and Children Coverage [or Associate and Spouse Coverage to Family Coverage] and provide notification of the additional premium due.

WHEN YOU CAN ENROLL OR CHANGE YOUR COVERAGE

You may apply for or change coverage as permitted under the terms of the policyholder's Health and Welfare Plan.

ELIGIBILITY DATE

If you are working for the policyholder in an eligible class, the date you are eligible for coverage is the later of:

1. the policy effective date; or
2. the date you become eligible for coverage under the terms of the policyholder's Health and Welfare Plan.

GENERAL PROVISIONS (Continued)

EFFECTIVE DATE OF COVERAGE

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If you enrolled for this coverage provided by us during your employer's initial enrollment period during the [Fall of 2009], your coverage is effective on [January 1, 2010]. If you enrolled for coverage anytime after your employer's initial enrollment period or anytime on or after [January 1, 2010], your coverage will be effective in accordance with the terms of the policyholder's Health and Welfare Plan.

For any change in coverage, the change in coverage is effective in accordance with the terms of the policyholder's Health and Welfare Plan.

CERTIFICATE OF INSURANCE

This certificate of insurance provides a description of the insurance provided by the policy issued to your employer. It describes the essential features of the insurance coverage and to whom benefits are payable.

If there is any discrepancy between the provisions of this certificate and the provisions of the policy, the provisions of the policy govern.

TERMINATION OF COVERAGE

Your coverage under the policy ends subject to the "Portability Coverage" provision of this certificate on the earliest of:

1. the date the policy is canceled by the policyholder; or
2. the last day of the period for which you made any required premium payments; or
3. the last day you are in active employment, except as provided under the "Leave of Absence" provision; or
4. the date you are no longer in an eligible class; or
5. the date your class is no longer eligible.

We will provide coverage for a payable claim that occurs while you are covered under the policy.

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death, or when you move to an eligible class that does not provide spouse coverage.

Coverage for a dependent child ends on the certificate anniversary next following the date the child is no longer eligible for coverage under the terms of the policyholder's Health and Welfare Plan. Coverage does not terminate for an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon you for support and maintenance.

The child's coverage continues as long as your coverage remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished to us when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims incurred after termination will not be paid. There may be no refund due if you have Associate and Child(ren) Coverage or Family Coverage and you have other dependent children insured.

Coverage may be eligible for continuation as outlined in the "Portability Coverage" provision.

AGENCY

For purposes of the policy, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed our agent.

GENERAL PROVISIONS (Continued)

LEAVE OF ABSENCE

If you cease active employment because of a leave of absence while coverage is in force, you will have the opportunity to continue your coverage while you are away from active employment. Coverage will be in accordance with the terms of the policyholder's Health and Welfare Plan. This includes, but is not limited to how coverage is provided, how premiums are paid for during the absence and whether coverage is reinstated upon return to employment.

INCONTESTABILITY

After 2 years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim.

6 [DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of the policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of the policy, such determinations shall be final and conclusive.]

LEGAL ACTION

No legal action may be brought to obtain benefits under the policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 180 days from the time a decision on appeal regarding a claim for benefits under this certificate has been rendered. A lawsuit may not be filed after this 180 day period expires.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder documenting any clerical errors.

BENEFICIARY; CHANGE OF BENEFICIARY

If no beneficiary is named, we will pay any benefits due at the covered person's death in the following order:

- 7
1. [to you, if living; otherwise
 2. to your spouse, if living; otherwise
 3. to the covered person's children, in equal shares, if living; otherwise
 4. to the covered person's parents, in equal shares, if living; otherwise
 5. to the covered person's siblings, in equal shares, if living; otherwise
 6. to the covered person's estate].

Any change of beneficiary must be filed with the policyholder or at our home office. It will not take effect unless so filed, but if so filed, will take effect on the date you signed it. This will be true whether or not the covered person is living on the date it is filed. There will be no prejudice to us on account of any payment we make prior to its receipt by us at our home office.

8 [UNPAID PREMIUM; EXCESS PREMIUM

Upon the payment of a claim under this certificate, any premium owed by you in an individual capacity that is more than [60 days] past due may be deducted from the benefit amount payable to you or one of your eligible dependents. Any excess premium will be refunded to you.]

PORTABILITY COVERAGE

We will provide portability coverage, subject to these provisions.

Such coverage will be available for a covered person, if the following criteria are satisfied:

1. coverage under the policy terminates as described in the General Provision entitled "Termination of Coverage"; and
2. we receive a request for portability and payment of the first premium for the portability coverage not later than [60 days] after such termination.

No portability coverage will be provided for any person, if his or her insurance under the policy terminated due to his or her failure to make required premium payments.

PORTABILITY COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under the policy. Any change made to the policy after a covered person is insured under the portability coverage will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after a covered person's coverage under the policy terminates.

PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance of each month of coverage to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate for the first [36 months] of portability coverage is the rate in effect under the policy for active associates who have the same coverage. After the first [36 months], the premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least [31 days] before any change is to take effect.

GRACE PERIOD

The grace period, as defined, will apply to each certificate holder of portability coverage as if such covered person is the policyholder.

TERMINATION OF PORTABILITY COVERAGE

Insurance under this portability coverage will automatically end on the earliest of the following dates:

1. the date you again become eligible for insurance under the policy; or
2. the last day for which premiums have been paid, if the covered person fails to pay premiums when due, subject to the grace period; or
3. with respect to insurance for dependents:
 - a. the date your insurance terminates; or
 - b. the date your dependent ceases to be an eligible dependent as defined.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

TERMINATION OF THE POLICY

If the policy terminates, you and your covered dependents will be eligible to exercise the portability privilege on the termination date of the policy. Portability coverage may continue beyond the policy's termination date, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.

LIMITATIONS AND EXCLUSIONS

The policy does not cover any loss incurred by a covered person as a result of:

1. an injury that occurred as the result of an on-the-job accident, except as may be provided under the On- and Off-the-Job Accident Only Intensive Care Unit Benefit; or
2. injury incurred prior to the covered person's effective date of coverage subject to the Incontestability provision; or
3. any act of war whether or not declared, participation in a riot, insurrection or rebellion; or
4. suicide, or any attempt at suicide, whether sane or insane; or
5. any injury sustained while the covered person is under the influence of alcohol or any narcotic, unless administered upon the advice of a physician; or
6. dental or plastic surgery for cosmetic purposes except when such surgery is required to treat an injury or correct a disorder of normal bodily function that was caused by an injury; or
7. participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or
8. committing or attempting to commit an assault or felony; or
9. driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway.

Any injury incurred while a covered person is an active member of the Military; Naval; or Air Forces of any country or combination of countries is not covered. Upon notice and proof of service in such forces, we will return the pro-rata portion of the premium paid for any period of such service.

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BENEFIT INFORMATION

OFF-THE-JOB ACCIDENT ONLY BENEFITS

If, while the policy is in force, a covered person sustains an injury caused by an off-the-job accident which results in any of the losses stated in this "Benefit Information" provision, and is diagnosed by a physician, we pay the following benefits for such loss. Any loss not stated in this "Benefit Information" provision is not covered under the policy.

- A. Emergency Treatment:** We pay \$120 for you or your covered spouse and \$70 for a covered child for required medical treatment as a result of a covered accident. This benefit is payable for physician fees, x-rays, and emergency room services. Treatment must be received within 72 hours of the covered accident. This benefit is payable only once for any and all treatment that occurs during any 24-hour period, per covered person, per covered accident.
- B. Follow-Up Treatment:** We pay \$25 per follow-up visit when a covered person requires additional follow-up treatment after receiving emergency treatment for which a benefit is paid under Emergency Treatment (benefit A). Follow-up treatment must be administered by a physician in a physician's office or in a hospital on an outpatient basis. Follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital. This benefit is payable for one follow-up treatment per day for a maximum of 6 treatments, per covered person, per covered accident. This benefit is not payable for treatments for which the Physical Therapy benefit (benefit R) is paid.
- C. Initial Hospitalization:** We pay \$1,000 the first time a covered person is hospital confined for at least 24 hours for treatment as a result of an injury; or \$1,500 if the covered person is admitted directly to a hospital intensive care unit. Confinement must start within 30 days of the covered accident. This benefit is payable only once per continuous hospital or intensive care unit confinement, per calendar year, per covered person.
- D. Hospital Confinement:** We pay a daily benefit of \$200 for a continuous hospital confinement, up to 365 days per covered accident, when a covered person is hospital confined for at least 18 hours for treatment as a result of an injury. Confinement must start within 30 days of the covered accident. This benefit is not payable for days on which the Rehabilitation benefit (benefit S) is paid. This benefit is paid in addition to the Initial Hospitalization benefit (benefit C).
- E. Intensive Care Unit Confinement:** We pay a daily benefit of \$400, up to 15 days for any one accident, per covered person, when a covered person is confined in a hospital intensive care unit, as a result of an injury. This benefit is paid in addition to the Initial Hospitalization benefit (benefit C) and the Hospital Confinement benefit (benefit D). Confinement must start within 30 days of the covered accident.
- F. Dislocation:** We pay the benefit amount shown in the chart below when a covered person sustains a dislocation as a result of a covered accident. This benefit is payable for only the first dislocation of a joint. If a covered dislocation is reduced with local anesthesia or no anesthesia by a physician, we will pay 25% of the benefit amount shown in the chart below. This benefit is payable for a maximum of 2 covered dislocations per covered person, per covered accident. If more than 2 dislocations occur during a covered accident, we will pay benefits for the 2 dislocations with the largest dollar amount benefits.

<u>Joint</u>	<u>Benefit Amount</u>
Hip	\$2,000
Collar bone	\$800
Knee or shoulder	\$500
Ankle or foot (excluding toes)	\$500
Lower jaw	\$500
Wrist or elbow	\$400
Toe or finger	\$100

BENEFIT INFORMATION (Continued)

OFF-THE-JOB ACCIDENT ONLY BENEFITS (Continued)

- G. Burns:** We pay the benefit amount shown in the chart below when a covered person sustains a burn as a result of an accident if treated by a physician within 72 hours after a covered accident. Injuries due to sunburn are not a covered benefit.

<u>Affected Area</u>	<u>Benefit Amount</u>	
	<u>2nd Degree</u>	<u>3rd Degree</u>
1 through 19 square centimeters of the body surface	\$100	\$200
20 through 39 square centimeters of the body surface	\$200	\$500
More than 40 but less than 65 square centimeters of the body surface	\$400	\$1,000
More than 65 but less than 160 square centimeters of the body surface	\$600	\$3,000
More than 160 but less than 225 square centimeters of the body surface	\$800	\$7,000
More than 225 square centimeters of the body surface	\$1,000	\$10,000

If the proof of loss does not specify the size of the burn, the lowest benefit amount shown will be paid.

- H. Skin Grafts:** We pay 50% of the benefit amount paid under the Burns benefit (benefit G) if a covered person receives one or more skin grafts for a covered burn. This benefit is paid in addition to the Burns benefit (benefit G).

- I. Eye Injury:** We pay \$250 for surgical repair or \$50 for removal of a foreign body by a physician if a covered person sustains an eye injury as a result of a covered accident.

- J. Lacerations:** We pay the benefit amount shown in the chart below when a covered person receives treatment for lacerations within 72 hours after a covered accident.

<u>Laceration</u>	<u>Benefit Amount</u>
Laceration(s) not requiring sutures	\$25
Single laceration less than 5 centimeters	\$50
Laceration(s) at least 5 centimeters but not more than 15 centimeters (total of all lacerations)	\$200
Laceration(s) over 15 centimeters (total of all lacerations)	\$400

If the proof of loss does not specify the size of the laceration, the lowest benefit amount shown will be paid.

- K. Fractures:** We pay the benefit amount shown in the chart below when a covered person sustains a fracture corrected by open or closed repair as a result of a covered accident. This benefit is payable for no more than 2 fractures per covered person, per covered accident. If more than 2 fractures occur during a covered accident, we will pay benefits for the 2 fractures with the largest dollar amount benefits.

<u>Fracture</u>	<u>Benefit Amount</u>
Hip	\$2,000
Skull	
depressed	\$1,500
simple	\$500
Leg	\$1,000
Rib	\$1,000
Vertebrae (body of), pelvis (excluding coccyx), or sternum	\$1,000
Vertebral processes	\$1,000
Upper jaw, upper arm, or face (excluding nose)	\$600
Hand (excluding fingers)	\$500
Foot (excluding toes/heel)	\$500
Lower jaw	\$500
Nose, heel, or finger	\$500
Shoulder blade or forearm	\$500
Wrist, elbow, ankle, or kneecap	\$500
Coccyx	\$200
Toe	\$200

We pay 25% of the amounts shown for chip fractures or other fractures not corrected by open or closed repair.

BENEFIT INFORMATION (Continued)

OFF-THE-JOB ACCIDENT ONLY BENEFITS (Continued)

- L. Emergency Dental Services:** We pay the benefit amount shown in the chart below when a covered person receives dental services as a result of an injury. This benefit is payable for no more than one dental benefit per covered person, per covered accident.

<u>Dental Service</u>	<u>Benefit Amount</u>
Broken teeth repaired with crowns	\$150
Broken teeth resulting in extractions	\$50

- M. Coma:** We pay \$10,000 if a covered person is in a coma as a result of a covered accident.

- N. Brain Concussion:** We pay \$50 if a covered person sustains a concussion as a result of a covered accident.

- O. Paralysis:** We pay the benefit amount shown in the chart below if a covered person suffers from spinal cord injury received in a covered accident which results in a complete and total loss of use of 2 or more limbs. Paralysis must last 30 or more consecutive days and must be confirmed by a physician. This benefit is only payable once per covered person.

<u>Paralysis</u>	<u>Benefit Amount</u>
Quadriplegia (Paralysis of 4 limbs)	\$10,000
Paraplegia (Paralysis of 2 limbs)	\$5,000

- P. Surgical Procedures:** We pay the benefit amount shown in the chart below if a covered person requires a surgical procedure as a result of a covered accident. Two or more surgical procedures performed through the same incision or entry point are considered 1 operation; we pay the amount for the procedure with the largest dollar amount benefit. Surgery must be performed within 1 year of a covered accident. Miscellaneous surgery is surgery that requires general anesthesia and is not covered by any other specific surgery benefit listed below. The miscellaneous surgery benefit is payable only once per 24 hour period even though more than 1 surgery or procedure may be performed.

<u>Surgery</u>	<u>Benefit Amount</u>
Open abdominal (including exploratory laparotomy), cranial, hernia, or thoracic surgery	\$1,000
Ruptured discs	\$500
Tendons and/or ligaments	\$500
Torn knee cartilages	\$500
Torn rotator cuffs	\$500
Arthroscopy without surgical repair	\$250
Miscellaneous surgery	\$250

- Q. Major Diagnostic Exams:** We pay \$150 if a covered person requires one of the following exams as a result of a covered injury: CT (computerized tomography) scan; MRI (magnetic resonance imaging); or EEG (electroencephalogram). The exam must be performed in a hospital, a physician's office, or an ambulatory surgical center. This benefit is limited to 1 payment per calendar year, per covered person.

- R. Physical Therapy:** We pay \$25 per day for physical therapy if a covered person receives physical therapy as a result of a covered injury. Therapy must be prescribed by a physician and begin within 30 days of the covered accident or discharge from the hospital and be received within the first 6 months after the covered accident or discharge from the hospital. This benefit is payable for 1 treatment per day for a maximum of 10 treatments per covered accident, per covered person. This benefit is not payable for treatments which the Follow-Up Treatment benefit (benefit B) is paid.

- S. Rehabilitation:** We pay \$100 per day if a covered person is confined to a rehabilitation unit as a result of a covered accident, provided that the covered person has been confined to a hospital immediately prior to being transferred to the rehabilitation unit. This benefit is paid for each day a room charge is incurred, up to 30 days for each covered person per continuous period of rehabilitation unit confinement, for a maximum of 60 days per calendar year. This benefit is not payable for days in which the Hospital Confinement benefit (benefit D) is paid.

BENEFIT INFORMATION (Continued)

OFF-THE-JOB ACCIDENT ONLY BENEFITS (Continued)

- T. Appliances:** We pay \$100 if a covered person, as a result of a covered injury and upon the advice of a physician, requires the use of a medical appliance as an aid in personal locomotion or mobility. Covered medical appliances are: crutches; wheelchair; leg brace; back brace; and walker. This benefit is payable only once per covered person, per covered accident.
- U. Prosthesis:** We pay \$500 if a covered person requires a prosthetic device as a result of a covered injury. This benefit is not payable for hearing aids, wigs, or any dental aids including false teeth. This benefit is payable only once per covered person, per covered accident.
- V. Blood, Plasma and/or Platelets:** We pay \$100 if a covered person, as a result of a covered injury, requires blood, plasma, and/or platelets. This benefit is not payable for immunoglobulins and is payable only once per covered person, per covered accident.
- W. Ambulance:** We pay \$150 for ground ambulance or \$1,000 for air ambulance if a covered person requires ambulance transportation to a hospital or emergency center as a result of a covered injury. The ambulance transportation must occur within 72 hours of the covered accident. Service must be provided by a licensed professional ambulance company.
- X. Transportation:** We pay \$400 per round trip for treatment at a non-local hospital as the result of a covered accident. This benefit is payable for only the covered person for whom the treatment is prescribed, except that if the treatment is for a covered dependent child and travel by common carrier is necessary, we pay an additional \$400 per round trip for one of the dependent child's parents or legal guardians to travel with the child. A physician must prescribe the treatment. This benefit is payable for up to 3 round trips per calendar year, per covered person. This benefit is not payable for transportation by ambulance or air ambulance to the hospital.
- Y. Family Lodging:** We pay \$100 per night for one motel/hotel room for an immediate family member to accompany the covered person who requires non-local hospital confinement as a result of a covered accident. This benefit is payable for up to 30 days per covered accident, and only during the days the covered person is confined in the hospital.
- Z. Accidental Death and Dismemberment:** We pay the benefit amount shown in the chart below if death or dismemberment occurs as a result of an injury sustained in a covered accident within 90 days of such accident. If more than 1 dismemberment is sustained in any 1 accident, the total amount we will pay will not exceed the highest single benefit for accidental dismemberment. Benefits are payable only once for any covered accident. If death and dismemberment result from the same accident, only the Accidental Death benefit will be paid. This benefit is paid regardless of whether the dismembered body part is surgically reattached.

<u>Accidental Death</u>	<u>Common Carrier</u>	<u>Other Accidents</u>		
Insured Associate:	\$100,000	\$25,000		
Covered Spouse:	\$100,000	\$25,000		
Covered Child:	\$15,000	\$7,500		
	<u>Both arms and both legs</u>	<u>2 eyes, feet, hands, arms or legs</u>	<u>1 eye, foot, hand, arm or leg</u>	<u>1 or more fingers and/or 1 or more toes</u>
Insured Associate:	\$25,000	\$25,000	\$6,250	\$1,250
Covered Spouse:	\$25,000	\$25,000	\$6,250	\$1,250
Covered Child:	\$7,500	\$7,500	\$1,875	\$500

BENEFIT INFORMATION (Continued)

ON- AND OFF-THE-JOB ACCIDENT ONLY INTENSIVE CARE UNIT BENEFIT

- A. Intensive Care Unit:** We pay a daily benefit of \$600 when a covered person is confined to an intensive care unit for at least 18 hours as a result of an injury from a covered on-the-job accident. This benefit is payable for up to 15 days per covered person, per covered accident. Confinement must start within 30 days of the accident.
- B. Step-down Intensive Care Unit Confinement:** We pay a daily benefit of \$200 for an off-the-job accident or \$400 for an on-the-job accident when a covered person is confined to a step-down intensive care unit for at least 18 hours as a result of an injury sustained from a covered accident. This benefit is payable in addition to any Hospital Confinement benefit (benefit D) payable for a covered accident. This benefit is payable for up to 15 days per covered person, per covered accident.

WELLNESS BENEFIT

10 Wellness: We pay [\$75] per certificate year, for either you or one other covered person, when an eligible examination or test is performed, after your coverage has been in force for at least 12 months. The test must be performed under the supervision of or recommended by a physician, while coverage is in force, and a charge must be incurred. We will pay this benefit regardless of the result of the examination or test. The eligible wellness examinations and tests are:

1. [annual physical examination; and
2. dental examination; and
3. mammography; and
4. pap smear; and
5. eye examination; and
6. immunization; and
7. flexible sigmoidoscopy; and
8. PSA (prostate specific antigen – blood test for prostate cancer); and
9. ultrasound; and
10. blood screening].

[If you were insured by the prior accident policy offered through the policyholder's Health and Welfare Plan, the length of time your prior coverage was in effect will reduce the waiting period for receiving benefits under this wellness benefit.]

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CLAIM INFORMATION

NOTICE OF CLAIM

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We encourage covered persons to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim must be given to us within 60 days after the occurrence or commencement of any loss covered by the policy, or as soon as reasonably possible. Notice given by, or on behalf of, a covered person or the beneficiary, to us at [PO Box 41488, Jacksonville FL 32203-1488], with the covered person's name and certificate number, is notice to us.

A claim form can be requested from us. If it is not received within 15 days of the request, notice of the claim may be sent to us by providing us a statement of the nature and extent of the loss.

FILING A CLAIM

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[If a covered person's claim is denied, a notice will be sent within a reasonable time period, but not longer than 90 days from receipt of the claim. If we determine that an extension is necessary due to special circumstances, this time may be extended for an additional 90 days. The covered person will receive notice before the extension that indicates the special circumstances requiring the extension and the date by which we expect to render a determination.

If the claim is in part or wholly denied, the covered person will receive notice of an adverse benefit determination that will:

- state the specific reason(s) for the adverse benefit determination; and
- reference the specific policy provisions on which the determination is based; and
- describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary; and
- describe the policy's claims review procedures and the time limits applicable to such procedures, including a statement of the covered person's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.]

PROOF OF CLAIM

Written proof must be given to us within 90 days of each loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 15 months from the time specified unless the covered person is legally incapacitated.

COOPERATION OF BENEFICIARY

The beneficiary must reasonably cooperate during any investigation and/or adjudication of a claim. This includes the authorization for the release of medical records and other information.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have any covered person examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of contestability, where it is not forbidden by law.

PAYMENT OF CLAIMS

After receiving written proof of claim, we will pay all benefits then due under the policy and will make payment to you, unless you have assigned the benefit to someone else. Any amounts unpaid at your death may, at our option, be paid either to the named beneficiary or as described in the "Beneficiary; Change of Beneficiary" provision.

CLAIM INFORMATION (Continued)

ASSIGNMENT

An assignment of the coverage under the policy is not binding on us, unless:

1. it is a written request; and
2. it is received and recorded by us at our home office.

We are not responsible for the validity of any assignment. An assignment is subject to any payment we make or other action we take before we record the assignment. An assignment may not change the owner or beneficiary.

OVERPAID CLAIM

We have the right to recover any overpayments due to:

1. fraud; or
2. any error we make in processing a claim.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid.

CLAIM REVIEW

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[A covered person will have 60 days from the receipt of an adverse benefit determination to file an appeal. Requests for appeals should be sent to [American Heritage Life Insurance Company, PO Box 41488, Jacksonville FL 32203-1488].

The covered person will have the opportunity to submit written comments, documents, or other information in support of the appeal, and the covered person will have access to all documents that are relevant to the claim.

The covered person will be notified of our benefit determination on review within a reasonable time, but not later than 60 days from receipt of the request for review. If we determine that an extension is necessary due to special circumstances, this time may be extended for an additional 60 days. The covered person will receive notice before the extension that indicates the special circumstances requiring the extension and the date by which we expect to render a determination.

If the claim is in part or wholly denied, the covered person will receive notice of an adverse benefit determination that will:

- state specific reason(s) of the adverse determination;
- reference specific policy provision(s) on which the benefit determination is based;
- state that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- describe any voluntary appeal procedures offered by the policy and the covered person's right to obtain information about such procedures; and
- include a statement regarding the covered person's right to bring an action under section 502(a) of ERISA.]

(This space intentionally left blank.)

GLOSSARY

Active Employment. Means that you are working for the employer for earnings that are paid regularly and are performing the material and substantial duties as assigned by your employer. You will be deemed to be in active employment on a day which is not one of the employer's scheduled work days only if actively employed on the preceding scheduled work day. Temporary and seasonal workers are excluded from coverage.

The location at which you perform work must be:

1. your employer's usual place of business; or
2. an alternative work site at the direction of your employer; or
3. a location to which your job requires you to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment.

Associate. Means a person who is: (1) a citizen or resident of the United States or one of its territories; and (2) in active employment with the employer named as the policyholder.

Associate-Only Coverage. Means coverage that includes only you, as defined.

Associate and Child(ren) Coverage. Means coverage that includes only you, as defined, and eligible children.

[Associate and Spouse Coverage. Means coverage that includes only you, as defined, and your spouse.]

Calendar Year. Means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

Certificate Year. Means a consecutive 12 month period beginning on the effective date of insurance for each insured associate.

Coma. Means a continuous state of profound unconsciousness which lasts 7 or more consecutive days as a result of a covered accident. A coma is characterized by an absence of spontaneous eye movements, response to painful stimuli and vocalization. The condition must require intubation for respiratory assistance. Medically induced comas are excluded.

Common Carrier. Means only the following: commercial airlines; passenger trains; inter-city buslines; trolleys; or boats. It does not include taxis; intra-city buslines or private charter planes.

Continuous Hospital Confinement. Means one continuous confinement or two or more hospital confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Covered Accident. Means a sudden, unforeseen and unexpected event which occurs without the covered person's intent which results in an injury to the covered person and for which benefits are payable.

Covered Person. Means any of the following:

1. any eligible family member (including you) named in the enrollment or evidence of insurability form and acceptable for coverage by us; or
2. any eligible dependent added after the effective date; or
3. a newborn child or adopted child subject to the "Eligibility of Dependents" provision.

Day. A 24 hour period.

Eligibility Waiting Period. Means the continuous period of time that you must be in active employment in an eligible class before you are eligible for coverage.

Employer. Means the individual, company or corporation where you are in active employment, and includes any division, subsidiary, or affiliated company named in the policy.

Family Coverage. Means coverage that includes you, as defined, and your eligible dependents.

GLOSSARY (Continued)

Fracture. Means a break in a bone that can be seen by X-ray and can be corrected by open (surgery) or closed (manipulative) repair.

14 Grace Period. Means a period of [60 days] following the premium due date during which premium payment may be made. While the associate is employed with the policyholder, the premiums will be paid by the policyholder through payroll deductions. The grace period only applies to the Associate during any portability period, when Associates will be required to pay the premiums directly to us.

Hospital. Means a legally operated institution with established facilities (either on its premises or available to the hospital on a contractual, pre-arranged basis and under the supervision of a staff of one or more duly licensed physicians), for the care and treatment of sick and injured persons for diagnosis, surgery, and 24 hour nursing service. Hospital does not include:

1. any institution which is mainly a rest home, nursing home, convalescent home, or home for the aged; or
2. any institution which is mainly for the care and treatment of alcoholics or drug addicts, or mental or nervous disorders.

Hospital Confined or Confinement. Means confinement as an inpatient in a hospital for which a room and board charge is made by the hospital. It does not include confinement for an observation room or a fractional part of a day.

Hospital Intensive Care Unit. Means a hospital area of special care, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds, or wards normally used for patient confinement. In addition, the unit must provide the following:

1. 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis; and
2. direction and/or supervision by a full-time physician director or a standing "intensive care" committee of the medical staff; and
3. special medical apparatus used to treat the critically ill.

Hospital Intensive Care Unit Confinement. Means 1 continuous confinement or 2 or more hospital intensive care unit confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Immediate Family Member. Means spouse, mother, father, child, step-child, adopted child.

Injury. Means a bodily injury caused directly by an accident, independent of sickness, disease, bodily infirmity, or any other cause, occurring on or after the effective date of coverage and while coverage is in force. See the Limitations and Exclusions section for injuries not covered by the policy.

Inpatient. Means a covered person who is a resident patient using the room and board facilities of a hospital.

Insured Associate. Means an associate who has: (1) fulfilled all eligibility requirements set forth in the policy and the policyholder's Health and Welfare Plan; and (2) properly completed and signed the enrollment, provided that the enrollment has been received by us.

Leave of Absence. Means you are absent from active employment for a period of time that has been agreed to in advance in writing by your current employer. Normal vacation time or any period of disability is not considered a leave of absence.

Non-local. Means more than 100 miles from the covered person's home or site of the accident.

Nurse. Means any one of the following who is not a member of the covered person's immediate family or employed by the hospital where the covered person is confined:

1. licensed practical nurse (L.P.N.); or
2. licensed vocational nurse (L.V.N.); or
3. graduate registered nurse (R.N.).

GLOSSARY (Continued)

Off-the-Job Accident. Means an accident that occurs while a covered person is not working at any job for pay or benefits.

On-the-Job Accident. Means an accident that occurs while a covered person is working at any job for pay or benefits.

Paralysis. Means spinal cord injuries received in a covered accident that result in complete and permanent loss of function of two or more limbs for a period of not less than 30 days. Paralysis must be confirmed by the attending physician.

Payable Claim. Means a claim for which we are liable under the terms of the policy.

Physician. Means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the state he or she practices in.

We will not recognize you, your spouse, children, parents, or siblings as a physician for a claim.

Policyholder. Means the legal entity to whom the policy is issued.

Rehabilitation Unit. Means a hospital area providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a physician who is knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

Step-down Intensive Care Unit. Means a hospital area of special care, which provides a level of medical care below the highest level of acute medical care available at the hospital, but above the level of medical care in a regular private or semiprivate room or ward. The facility is separate and apart from the surgical recovery room, other rooms, beds, or wards normally used for patient confinement. In addition, the unit must provide 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis.

Under the Influence. Means a condition as determined by the laws of the state in which the loss occurred.

We, Us and Our. Means American Heritage Life Insurance Company.

You, Your or Yours. Means the insured associate, as defined, who meets the eligibility requirements.

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[STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as division offices, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to annually furnish each participant with a copy of the summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people who operate your Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including the Employer or any other person, may fire or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request materials for the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. Generally, you must complete the appeals process before filing a law suit against the Plan. However, you should consult with your own legal counsel in determining when it is proper to file a law suit against the Plan.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest regional office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration publications hotline at (866) 444-3272 or by logging on to the Internet at www.dol.gov/ebsa.]

[ADMINISTRATIVE INFORMATION

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Plan Year: January 1 through December 31

Plan Number: 501

Type of Plan: Welfare benefit plan

Type of Administration: The Plan allocates discretionary authority among Committees (or their delegates) concerning the administration, interpretation, and application of the Plan. The Plan also provides that discretionary authority over claims for benefits and appeals may be allocated to, among others, an insurance carrier of an insured benefit.

Plan Sponsor:

Wal-Mart Stores, Inc.
702 SW 8th Street
Bentonville, AR 72716

Plan Administrator/Named Fiduciary:

The Administrative Committee
Associates' Health and Welfare Plan
922 West Walnut, Ste. A
Rogers, AR 72756-3540
(479) 621-2058

Agent for Service of Legal Process:

Corporation Trust Company
1209 Orange Street
Corporation Trust Center
Wilmington, DE 19801
Legal process may also be served on the Plan Administrator or Trustee.

Plan Sponsor's EIN: 71-0415188

Funding: Contributions to the Plan may be made by Wal-Mart Stores, Inc. out of its general assets or through the Associates' Health and Welfare Plan Master Trust. Contributions also may be required by employees, in an amount determined by Wal-Mart Stores, Inc. in its discretion. All assets of the Plan, including Associate contributions and any dividends or earnings thereon, shall be available to pay any benefits provided under the Plan or expenses of the Plan, including insurance premiums.

Plan Trustee: JP Morgan Chase Bank, N.A.

Plan Documents: This document, together with the current version of the Associate Benefits Book, constitutes the summary plan description (SPD) for the accident coverage portion of the Plan. The SPD, together with the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan Wrap Document, are the Plan documents for the Plan.

Plan Amendment or Termination: Wal-Mart reserves the right to amend or terminate at any time and to any extent the SPD, including the Associate Benefits Book, and the Associates' Health and Welfare Plan Wrap Document. None of the benefits described in this Document can be orally amended. All oral statements and representations shall be without force or effect even if such statements and representations are made by the Plan Administrator, by a management Associate of the Company, or by any member of the applicable committees of the Plan. Only written statements by the applicable committee of the Plan shall bind the Plan.]



Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

**THIS IS A GROUP ACCIDENT CERTIFICATE WHICH ONLY PROVIDES BENEFITS FOR
OFF-THE-JOB ACCIDENTS AS DEFINED AND ON- AND OFF-THE-JOB ACCIDENT
INTENSIVE CARE UNIT BENEFIT AS DEFINED WITHIN THIS CERTIFICATE
AND OTHER BENEFITS SPECIFICALLY DESCRIBED HEREIN.
THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**



Allstate

Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224

WALMART [EVIDENCE OF INSURABILITY (PROOF OF GOOD HEALTH) AND] ENROLLMENT FORM

This box for AHL Home Office use only

GENERAL INFORMATION SECTION

(Please complete entire section)

Please print with black ink

ASSOCIATE'S NAME Last (Sr, Jr, etc.)	First	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER	HEIGHT	WEIGHT	<input type="checkbox"/> Married <input type="checkbox"/> Single
RESIDENCE ADDRESS (Street or P.O. Box)				CITY	STATE	ZIP	
BIRTHDATE (MM/DD/YEAR)	RESIDENCE PHONE NUMBER	EMPLOYER CASE NUMBER WMART			DATE HIRED (MM/DD/YEAR)		
OCCUPATION N/A	SITUS STATE AR	PLANT OR DIVISION N/A	ASSOCIATE'S [WIN] ID NUMBER N/A				

SELECTION OF COVERAGE SECTION

Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Associate Only	<input type="checkbox"/> New Election
	<input type="checkbox"/> Associate+Spouse	<input type="checkbox"/> Status Change Election _____
	<input type="checkbox"/> Associate+Child(ren)	Reason for Change _____
	<input type="checkbox"/> Family]	Date of Event _____

Critical Illness <input type="checkbox"/> Yes <input type="checkbox"/> No Basic Benefit Amount \$ _____	<input type="checkbox"/> Associate Only	<input type="checkbox"/> New Election
	<input type="checkbox"/> Associate+Spouse	<input type="checkbox"/> Status Change Election _____
[Guarantee Issue Amount of \$5,000, \$10,000, or \$15,000. Amounts of \$20,000, \$25,000, \$30,000, \$40,000 or \$50,000 can be elected subject to proof of good health.]	<input type="checkbox"/> Associate+Child(ren)	Reason for Change _____
	<input type="checkbox"/> Family]	Date of Event _____

[DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Choose Plan(s):		Dependent's Name(s) (Last, First, M.I.)	Relationship	Gender	Date of Birth (MM/DD/YEAR)
Accident	Critical Illness				

[BENEFICIARY SECTION

(Please select your beneficiary. Use additional paper if needed.)

For Plan(s):		Name of Beneficiary (Last, First, M.I.)	Relationship	Age	Primary, Secondary or Tertiary	Allocation
Accident	Critical Illness					
						%
						%
						%
						%

*Allocations for Primary, Secondary and Tertiary Beneficiaries should equal 100%.

**WALMART [EVIDENCE OF INSURABILITY (PROOF OF GOOD HEALTH)
AND] ENROLLMENT FORM
[PROOF OF GOOD HEALTH SECTION FOR CRITICAL ILLNESS**

Initial Enrollment. Please answer each question if you are requesting a Basic Benefit Amount of [\$20,000] or more.

Increase And Post Initial Enrollment. Please answer each question if you are applying for an increase in coverage or if you are applying any time after your initial enrollment period.

Non-Medical Question			
1. Is the proposed insured actively at work now and has he/she worked each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, normal pregnancy or other leaves of absence that are not related to his/her own illness or injury?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	N/A
Medical Questions			
2. Has any person proposed for coverage been diagnosed, treated, or anticipate being treated for any of the following: Sickle Cell Anemia; Lupus; Tuberculosis; HIV Acquired Immune Deficiency Syndrome ("AIDS"); AIDS Related Complex ("ARC"); Alzheimer's Disease; Kidney Failure; Emphysema; Circulatory Disorders; Diabetes; Epilepsy; any form of Hepatitis; Liver Disorders; or any disorder of the Kidneys, Prostate, Lungs, and/or Pancreas?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has any person proposed for coverage had or been recommended to have an Organ Transplant?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any person proposed for coverage been diagnosed, treated for or counseled in the last 5 years for: Alcohol; Drug Abuse; Asthma; any Cancer (except basal cell skin cancer) or any Malignancy; any Heart Conditions, Heart Attack, Stroke, Transient Ischemic Attack (TIA), or any other abnormality of the Heart including High Blood Pressure with readings of 150 systolic or 100 diastolic more than once in the last year?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Initial Enrollment. If the associate answers "no" to Question 1 or "yes" to Questions 2, 3, or 4, we will issue the guaranteed issue amount of [\$15,000]. If the spouse answers "yes" to Questions 2, 3, or 4, the spouse's Basic Benefit Amount is [\$15,000]. If any dependent child answers "yes" to Questions 2, 3, or 4, all children are issued a Basic Benefit Amount of [\$15,000].

Increase And Post Initial Enrollment. If you answer "no" to Question 1 or "yes" to Questions 2, 3, or 4, you are not eligible for the requested coverage.]

[If you elect child(ren) coverage, please list all children in the dependent section and answer the child(ren) medical questions if required based on all of your children, even if you have not enrolled them in other products.]

[DELIVERY NOTICE: Your certificate of insurance will be made available to you by your employer in electronic form. Included with the certificate will be privacy and other legal notices. To access your certificate and these legal notices, you will need a personal computer with internet access and appropriate browser software, and Adobe® Acrobat® Reader® software. Unless you decline below, you agree to receive these legal notices with the certificate of insurance in electronic form provided by your employer. At any time, you may withdraw your consent and receive a paper copy of these legal notices by calling 1-800-514-9525; or by writing to American Heritage Life Insurance Company, PO BOX 41488, Jacksonville, FL 32203-1488.

I decline electronic delivery of the certificate and the legal notices. Please mail them to me.]

[CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

I CERTIFY that the statements and answers provided are made by me, are complete and true, are correctly and fully recorded and that no important circumstance or information has been withheld or omitted. These statements and answers are offered to AHL as an inducement to grant insurance, and I understand that AHL may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this Evidence of Insurability (Proof of Good Health) and Enrollment Form. · **I AUTHORIZE** my employer to deduct from my salary or wages the necessary premium for the coverage(s) requested. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.]

FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Associate's Signature _____ Signed at _____ Date Signed _____
(City and State)



Workplace Division

**AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224**

**WALMART [EVIDENCIA DE ASEGURABILIDAD (PRUEBA DE BUEN ESTADO DE SALUD)
Y] FORMULARIO DE INSCRIPCIÓN**

This box for AHL Home Office use only (Esta casilla es solo para uso de la oficina central de AHL)

Sírvase escribir en letra de imprenta con tinta negra

SECCIÓN DE INFORMACIÓN GENERAL
(Llene la sección completa)

NOMBRE DEL ASOCIADO Apellido (Sr., Jr., etc.) Nombre Inicial del segundo nombre		<input type="checkbox"/> H <input type="checkbox"/> M	NÚMERO DE SEGURO SOCIAL	ESTATURA	PESO	<input type="checkbox"/> Casado(a) <input type="checkbox"/> Soltero(a)
DIRECCIÓN PARTICULAR (Calle o casilla de correo)			CIUDAD	ESTADO	CÓDIGO POSTAL	
FECHA DE NACIMIENTO (MM/DD/AÑO)	NÚMERO DE TELÉFONO PARTICULAR	EMPLEADOR NÚMERO DE CASO WMART		FECHA DE CONTRATACIÓN (MM/DD/AÑO)		
OCUPACIÓN N/A	ESTADO SEDE AR	PLANTA O DIVISIÓN N/A	NÚMERO DE DOCUMENTO DE [WIN] IDENTIDAD DEL ASOCIADO			

SECCIÓN DE SELECCIÓN DE COBERTURA

Accidente <input type="checkbox"/> Sí <input type="checkbox"/> No	[<input type="checkbox"/> Asociado solamente <input type="checkbox"/> Asociado + Cónyuge <input type="checkbox"/> Asociado + Hijo(s) <input type="checkbox"/> Familiar]	<input type="checkbox"/> Elección nuevo <input type="checkbox"/> El cambio de elección de estatus _____ Razón del cambio _____ Fecha del evento _____

Enfermedad grave <input type="checkbox"/> Sí <input type="checkbox"/> No Monto de beneficio básico \$ _____ <small>[Monto de emisión de garantía de \$5,000, \$10,000 o \$15,000. Se pueden elegir montos de \$20,000, \$25,000, \$30,000, \$40,000 o \$50,000, sujeto a prueba de buen estado de salud.]</small>	[<input type="checkbox"/> Asociado solamente <input type="checkbox"/> Asociado + Cónyuge <input type="checkbox"/> Asociado + Hijo(s) <input type="checkbox"/> Familiar]	<input type="checkbox"/> Elección nuevo <input type="checkbox"/> El cambio de elección de estatus _____ Razón para el cambio _____ Fecha del evento _____

[SECCIÓN DE COBERTURA DE DEPENDIENTES

(Completar si se elige cobertura de dependientes. Use hojas adicionales de ser necesario).

Elija los planes:		Nombres de los dependientes (Apellido, nombre, inicial del segundo nombre)	Parentesco	Género	Fecha de nacimiento (MM/DD/AÑO)
Accidente	Enfermedad grave				

[SECCIÓN DEL BENEFICIARIO

(Seleccione su beneficiario. Use hojas adicionales de ser necesario).

Para los planes:		Nombre del beneficiario (Apellido, nombre, inicial del segundo nombre)	Parentesco	Edad	Primario, secundario o terciario	Asignación
Accidente	Enfermedad grave					
						%
						%
						%
						%

*Las asignaciones para beneficiarios primarios, secundario o terciario deben ser equivalentes al 100%.

**WALMART [EVIDENCIA DE ASEGURABILIDAD (PRUEBA DE BUEN ESTADO DE SALUD)
Y] FORMULARIO DE INSCRIPCIÓN**

[SECCIÓN DE PRUEBA DE BUEN ESTADO DE SALUD PARA ENFERMEDAD GRAVE

Inscripción inicial. Responda a cada pregunta en caso de solicitar un monto de beneficio básico de [\$20,000] o más.

Inscripción de incremento y posterior a la inicial Responda a cada pregunta en caso de solicitar un incremento de cobertura o en caso de solicitar la inscripción en algún momento posterior a su período inicial de inscripción.

Pregunta no médica			
1. ¿Se encuentra el asegurado propuesto trabajando activamente en la actualidad y ha trabajado cada semana realizando todas las actividades en su ocupación regular y en su lugar de empleo regular durante los últimos 3 meses, a excepción de enfermedades o lesiones menores con una duración de 1 semana o menos, licencia por un embarazo normal u otras licencias no relacionadas con su propia enfermedad o lesión?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	N/D	N/D
Preguntas médicas			
2. ¿A alguna persona propuesta para cobertura se le ha diagnosticado, tratado o se anticipa que será tratada por cualquiera de las siguientes: anemia drepanocítica; lupus; tuberculosis; síndrome de inmunodeficiencia adquirida por VIH (“SIDA”); complejo relacionado con el SIDA (AIDS related complex, “ARC”); enfermedad de Alzheimer; insuficiencia renal; enfisema; trastornos circulatorios; diabetes; epilepsia; cualquier forma de hepatitis; trastornos hepáticos; o cualquier trastorno de los riñones, la próstata, los pulmones y/o el páncreas?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No
3. ¿A alguna persona propuesta para cobertura se ha sometido o se le ha aconsejado realizarse un trasplante de órgano?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No
4. ¿A alguna persona propuesta para cobertura se le ha diagnosticado, tratado o aconsejado en los últimos 5 años por alguno de los siguientes: alcohol; drogadicción; asma; cualquier cáncer (excepto cáncer de piel de células basales) o cualquier otro tumor; cualquier afección cardíaca, ataque al corazón, accidente cerebrovascular, ataque isquémico transitorio (transient ischemic attack, TIA) o cualquier otra anomalía del corazón, incluida presión arterial alta con lecturas de 150 sistólica o 100 diastólica más de una vez durante el último año?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No

Inscripción inicial. Si el asociado responde “no” a la pregunta 1 o “sí” a las preguntas 2, 3 ó 4, emitiremos el monto de emisión garantizada de [\$15,000]. Si el cónyuge responde “sí” a las preguntas 2, 3 ó 4, el monto de beneficio básico del cónyuge es de [\$15,000]. Si cualquier hijo dependiente responde “sí” a las preguntas 2, 3 ó 4, a todos los hijos se les emite un monto de beneficio básico de [\$15,000].

Inscripción de incremento y posterior a la inicial Si usted responde “no” a la pregunta 1 o “sí” a las preguntas 2, 3 ó 4, usted no es elegible para la cobertura solicitada].

Si elige cobertura para hijo(s), enumere todos sus hijos en la sección de dependientes y responda a las preguntas médicas correspondientes a su(s) hijo(s), si así se requiere, en base a todos ellos, aun cuando no los haya inscrito en otros productos.

[NOTIFICACIÓN DE ENTREGA: Su certificado de seguro será puesto a disposición suya por parte de su empleador en forma electrónica. Junto con el certificado, habrá notificaciones legales y sobre privacidad. Para acceder a su certificado y a estas notificaciones legales, necesitará una computadora personal con conexión a Internet y un programa de navegación apropiado, y también el programa Adobe® Acrobat® Reader®. A menos que usted manifieste lo contrario a continuación, acepta recibir estas notificaciones legales con el certificado de seguro en forma electrónica por parte de su empleador. En cualquier momento, puede retirar su consentimiento y recibir una copia impresa de estas notificaciones legales llamando al 1-800-937-7039 o escribiendo a Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, FL 32224.

No acepto la entrega de las notificaciones legales por medios electrónicos. Sírvanse enviármelas por correo.]

[CERTIFICACIÓN, ENTENDIMIENTO Y AUTORIZACIONES

CERTIFICO que los enunciados y las respuestas provistos son efectuados por mí, son completos y verdaderos, han sido registrados correcta e íntegramente y que ninguna circunstancia o información importante ha sido retenida u omitida. Estos enunciados y respuestas se ofrecen a AHL a modo de inducción para la concesión de seguro, y entiendo que AHL podrá usar cualquier enunciado o declaración falsos para disputar la validez de cualquier cobertura provista sobre la base de esta Evidencia de Asegurabilidad (prueba de buen estado de salud) y Formulario de inscripción. • **AUTORIZO** a mi empleador a deducir de mi salario o sueldo la prima necesaria para las coberturas solicitadas. Entiendo que si rechazo cualquier cobertura para la cual soy elegible, se puede requerir prueba de asegurabilidad satisfactoria, por mi cuenta y cargo, en caso de que desee solicitarla en una fecha futura. Tal solicitud podría ser denegada sobre la base de dicha prueba.]

NOTIFICACIÓN SOBRE FRAUDE: Cualquier persona que, a sabiendas, presente un reclamación falsa o fraudulenta por el pago de una pérdida o beneficio o que, a sabiendas, presente información falsa en una solicitud de seguro será culpable de un crimen y podrá estar sujeta a multas y encarcelamiento.

Firma del asociado _____ Firmado en _____ Fecha de la firma _____
(Ciudad y estado)

SERFF Tracking Number: ALST-126282608 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 43415
 Company Tracking Number: GVA WALMART
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Group Accident for Walmart
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	09/09/2009
Comments:		
Attachment: GAWM Readability Certification.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	09/09/2009
Comments: GAAPAR is the Employer Application Form, it was previously approved in the initial filing and has not changed.		

The following forms have been revised and are also included in the Form Schedule Tab:

AWD4528WM is the Enrollment and Evidence of Insurability Form

AWD4528WMESP is the Enrollment and Evidence of Insurability Form in Spanish

Attachments:

GAAPPAR Employer application.pdf

Walmart Enrollment and EOI Form.pdf

Walmart Enrollment and EOI Form Spanish.pdf

	Item Status:	Status Date:
Satisfied - Item: General Amendment	Approved-Closed	09/09/2009
Comments: This form was previously approved in the initial filing and has not changed. G-AMD is an amendment form that will be used to make eligibility changes to the policy at the policyholder's request (i.e. adding additional classes of employees, changing waiting periods, etc.)		
Attachment: G-AMD.pdf		

Item Status:	Status Date:
---------------------	---------------------

SERFF Tracking Number: ALST-126282608 *State:* Arkansas
Filing Company: American Heritage Life Insurance Company *State Tracking Number:* 43415
Company Tracking Number: GVA WALMART
TOI: H02G Group Health - Accident Only *Sub-TOI:* H02G.000 Health - Accident Only
Product Name: Group Accident for Walmart
Project Name/Number: /
Satisfied - Item: Red-line documents **Item Status:** Approved-Closed **Status Date:** 09/09/2009

Comments:
 The attached show the changes being made to the policy and certificate from their last approved version.

Attachments:
 GAPWM Policy red-line version.pdf
 GACWM Certificate red-line version.pdf

Satisfied - Item: Variable Statement **Item Status:** Approved-Closed **Status Date:** 09/09/2009

Comments:
Attachment:
 GAPWM Variable Statement.pdf

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6687

To the Policy Review Section, ARKANSAS Department of Insurance.

I certify that I have carefully reviewed the form(s) listed below and to the best of my knowledge and ability, find that the form(s) meet the minimum reading ease score on the test used.

<u>Form</u>	<u>Score</u>
GAPWM	51.3
GACWM	51.6

Date: August 26, 2009



Diane D. Ierna
Assistant Vice-President Compliance Department



Allstate

Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224

WALMART [EVIDENCE OF INSURABILITY (PROOF OF GOOD HEALTH) AND] ENROLLMENT FORM

This box for AHL Home Office use only

GENERAL INFORMATION SECTION

(Please complete entire section)

Please print with black ink

ASSOCIATE'S NAME Last (Sr, Jr, etc.)	First	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER	HEIGHT	WEIGHT	<input type="checkbox"/> Married <input type="checkbox"/> Single
RESIDENCE ADDRESS (Street or P.O. Box)				CITY	STATE	ZIP	
BIRTHDATE (MM/DD/YEAR)	RESIDENCE PHONE NUMBER	EMPLOYER CASE NUMBER WMART			DATE HIRED (MM/DD/YEAR)		
OCCUPATION N/A	SITUS STATE AR	PLANT OR DIVISION N/A		ASSOCIATE'S [WIN] ID NUMBER N/A			

SELECTION OF COVERAGE SECTION

Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Associate Only	<input type="checkbox"/> New Election
	<input type="checkbox"/> Associate+Spouse	<input type="checkbox"/> Status Change Election _____
	<input type="checkbox"/> Associate+Child(ren)	Reason for Change _____
	<input type="checkbox"/> Family]	Date of Event _____

Critical Illness <input type="checkbox"/> Yes <input type="checkbox"/> No Basic Benefit Amount \$ _____	<input type="checkbox"/> Associate Only	<input type="checkbox"/> New Election
	<input type="checkbox"/> Associate+Spouse	<input type="checkbox"/> Status Change Election _____
[Guarantee Issue Amount of \$5,000, \$10,000, or \$15,000. Amounts of \$20,000, \$25,000, \$30,000, \$40,000 or \$50,000 can be elected subject to proof of good health.]	<input type="checkbox"/> Associate+Child(ren)	Reason for Change _____
	<input type="checkbox"/> Family]	Date of Event _____

[DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Choose Plan(s):		Dependent's Name(s) (Last, First, M.I.)	Relationship	Gender	Date of Birth (MM/DD/YEAR)
Accident	Critical Illness				

[BENEFICIARY SECTION

(Please select your beneficiary. Use additional paper if needed.)

For Plan(s):		Name of Beneficiary (Last, First, M.I.)	Relationship	Age	Primary, Secondary or Tertiary	Allocation
Accident	Critical Illness					
						%
						%
						%
						%

*Allocations for Primary, Secondary and Tertiary Beneficiaries should equal 100%.

**WALMART [EVIDENCE OF INSURABILITY (PROOF OF GOOD HEALTH)
AND] ENROLLMENT FORM
[PROOF OF GOOD HEALTH SECTION FOR CRITICAL ILLNESS**

Initial Enrollment. Please answer each question if you are requesting a Basic Benefit Amount of [\$20,000] or more.

Increase And Post Initial Enrollment. Please answer each question if you are applying for an increase in coverage or if you are applying any time after your initial enrollment period.

Non-Medical Question			
1. Is the proposed insured actively at work now and has he/she worked each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, normal pregnancy or other leaves of absence that are not related to his/her own illness or injury?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	N/A
Medical Questions			
2. Has any person proposed for coverage been diagnosed, treated, or anticipate being treated for any of the following: Sickle Cell Anemia; Lupus; Tuberculosis; HIV Acquired Immune Deficiency Syndrome ("AIDS"); AIDS Related Complex ("ARC"); Alzheimer's Disease; Kidney Failure; Emphysema; Circulatory Disorders; Diabetes; Epilepsy; any form of Hepatitis; Liver Disorders; or any disorder of the Kidneys, Prostate, Lungs, and/or Pancreas?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has any person proposed for coverage had or been recommended to have an Organ Transplant?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any person proposed for coverage been diagnosed, treated for or counseled in the last 5 years for: Alcohol; Drug Abuse; Asthma; any Cancer (except basal cell skin cancer) or any Malignancy; any Heart Conditions, Heart Attack, Stroke, Transient Ischemic Attack (TIA), or any other abnormality of the Heart including High Blood Pressure with readings of 150 systolic or 100 diastolic more than once in the last year?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Initial Enrollment. If the associate answers "no" to Question 1 or "yes" to Questions 2, 3, or 4, we will issue the guaranteed issue amount of [\$15,000]. If the spouse answers "yes" to Questions 2, 3, or 4, the spouse's Basic Benefit Amount is [\$15,000]. If any dependent child answers "yes" to Questions 2, 3, or 4, all children are issued a Basic Benefit Amount of [\$15,000].

Increase And Post Initial Enrollment. If you answer "no" to Question 1 or "yes" to Questions 2, 3, or 4, you are not eligible for the requested coverage.]

[DELIVERY NOTICE: Your certificate of insurance will be made available to you by your employer in electronic form. Included with the certificate will be privacy and other legal notices. To access your certificate and these legal notices, you will need a personal computer with internet access and appropriate browser software, and Adobe® Acrobat® Reader® software. Unless you decline below, you agree to receive these legal notices with the certificate of insurance in electronic form provided by your employer. At any time, you may withdraw your consent and receive a paper copy of these legal notices by calling 1-800-514-9525; or by writing to American Heritage Life Insurance Company, PO BOX 41488, Jacksonville, FL 32203-1488.

I decline electronic delivery of the certificate and the legal notices. Please mail them to me.]

[CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

I CERTIFY that the statements and answers provided are made by me, are complete and true, are correctly and fully recorded and that no important circumstance or information has been withheld or omitted. These statements and answers are offered to AHL as an inducement to grant insurance, and I understand that AHL may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this Evidence of Insurability (Proof of Good Health) and Enrollment Form. · **I AUTHORIZE** my employer to deduct from my salary or wages the necessary premium for the coverage(s) requested. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.]

FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Associate's Signature _____ Signed at _____ Date Signed _____
(City and State)



Workplace Division

**AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224**

**WALMART [EVIDENCIA DE ASEGURABILIDAD (PRUEBA DE BUEN ESTADO DE SALUD)
Y] FORMULARIO DE INSCRIPCIÓN**

This box for AHL Home Office use only (Esta casilla es solo para uso de la oficina central de AHL)

Sírvase escribir en letra de imprenta
con tinta negra

SECCIÓN DE INFORMACIÓN GENERAL

(Llene la sección completa)

NOMBRE DEL ASOCIADO Apellido (Sr., Jr., etc.) Nombre Inicial del segundo nombre		<input type="checkbox"/> H <input type="checkbox"/> M	NÚMERO DE SEGURO SOCIAL	ESTATURA	PESO	<input type="checkbox"/> Casado(a) <input type="checkbox"/> Soltero(a)
DIRECCIÓN PARTICULAR (Calle o casilla de correo)			CIUDAD	ESTADO	CÓDIGO POSTAL	
FECHA DE NACIMIENTO (MM/DD/AÑO)	NÚMERO DE TELÉFONO PARTICULAR	EMPLEADOR NÚMERO DE CASO WMART		FECHA DE CONTRATACIÓN (MM/DD/AÑO)		
OCUPACIÓN N/A	ESTADO SEDE AR	PLANTA O DIVISIÓN N/A	NÚMERO DE DOCUMENTO DE [WIN] IDENTIDAD DEL ASOCIADO			

SECCIÓN DE SELECCIÓN DE COBERTURA

Accidente <input type="checkbox"/> Sí <input type="checkbox"/> No	[<input type="checkbox"/> Asociado solamente <input type="checkbox"/> Asociado + Cónyuge <input type="checkbox"/> Asociado + Hijo(s) <input type="checkbox"/> Familiar]	<input type="checkbox"/> Elección nuevo <input type="checkbox"/> El cambio de elección de estatus _____ Razón del cambio _____ Fecha del evento _____
		<input type="checkbox"/> Sí <input type="checkbox"/> No Monto de beneficio básico \$ _____ <small>[Monto de emisión de garantía de \$5,000, \$10,000 o \$15,000. Se pueden elegir montos de \$20,000, \$25,000, \$30,000, \$40,000 o \$50,000, sujeto a prueba de buen estado de salud.]</small>

[SECCIÓN DE COBERTURA DE DEPENDIENTES

(Completar si se elige cobertura de dependientes. Use hojas adicionales de ser necesario).

Elija los planes:		Nombres de los dependientes (Apellido, nombre, inicial del segundo nombre)	Parentesco	Género	Fecha de nacimiento (MM/DD/AÑO)
Accidente	Enfermedad grave				

[SECCIÓN DEL BENEFICIARIO

(Seleccione su beneficiario. Use hojas adicionales de ser necesario).

Para los planes:		Nombre del beneficiario (Apellido, nombre, inicial del segundo nombre)	Parentesco	Edad	Primario, secundario o terciario	Asignación
Accidente	Enfermedad grave					
						%
						%
						%
						%

*Las asignaciones para beneficiarios primarios, secundario o terciario deben ser equivalentes al 100%.

**WALMART [EVIDENCIA DE ASEGURABILIDAD (PRUEBA DE BUEN ESTADO DE SALUD)
Y] FORMULARIO DE INSCRIPCIÓN**

[SECCIÓN DE PRUEBA DE BUEN ESTADO DE SALUD PARA ENFERMEDAD GRAVE

Inscripción inicial. Responda a cada pregunta en caso de solicitar un monto de beneficio básico de [\$20,000] o más.

Inscripción de incremento y posterior a la inicial Responda a cada pregunta en caso de solicitar un incremento de cobertura o en caso de solicitar la inscripción en algún momento posterior a su período inicial de inscripción.

Pregunta no médica			
1. ¿Se encuentra el asegurado propuesto trabajando activamente en la actualidad y ha trabajado cada semana realizando todas las actividades en su ocupación regular y en su lugar de empleo regular durante los últimos 3 meses, a excepción de enfermedades o lesiones menores con una duración de 1 semana o menos, licencia por un embarazo normal u otras licencias no relacionadas con su propia enfermedad o lesión?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	N/D	N/D
Preguntas médicas			
2. ¿A alguna persona propuesta para cobertura se le ha diagnosticado, tratado o se anticipa que será tratada por cualquiera de las siguientes: anemia drepanocítica; lupus; tuberculosis; síndrome de inmunodeficiencia adquirida por VIH (“SIDA”); complejo relacionado con el SIDA (AIDS related complex, “ARC”); enfermedad de Alzheimer; insuficiencia renal; enfisema; trastornos circulatorios; diabetes; epilepsia; cualquier forma de hepatitis; trastornos hepáticos; o cualquier trastorno de los riñones, la próstata, los pulmones y/o el páncreas?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No
3. ¿A alguna persona propuesta para cobertura se ha sometido o se le ha aconsejado realizarse un trasplante de órgano?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No
4. ¿A alguna persona propuesta para cobertura se le ha diagnosticado, tratado o aconsejado en los últimos 5 años por alguno de los siguientes: alcohol; drogadicción; asma; cualquier cáncer (excepto cáncer de piel de células basales) o cualquier otro tumor; cualquier afección cardíaca, ataque al corazón, accidente cerebrovascular, ataque isquémico transitorio (transient ischemic attack, TIA) o cualquier otra anomalía del corazón, incluida presión arterial alta con lecturas de 150 sistólica o 100 diastólica más de una vez durante el último año?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No

Inscripción inicial. Si el asociado responde “no” a la pregunta 1 o “sí” a las preguntas 2, 3 ó 4, emitiremos el monto de emisión garantizada de [\$15,000]. Si el cónyuge responde “sí” a las preguntas 2, 3 ó 4, el monto de beneficio básico del cónyuge es de [\$15,000]. Si cualquier hijo dependiente responde “sí” a las preguntas 2, 3 ó 4, a todos los hijos se les emite un monto de beneficio básico de [\$15,000].

Inscripción de incremento y posterior a la inicial Si usted responde “no” a la pregunta 1 o “sí” a las preguntas 2, 3 ó 4, usted no es elegible para la cobertura solicitada].

[NOTIFICACIÓN DE ENTREGA: Su certificado de seguro será puesto a disposición suya por parte de su empleador en forma electrónica. Junto con el certificado, habrá notificaciones legales y sobre privacidad. Para acceder a su certificado y a estas notificaciones legales, necesitará una computadora personal con conexión a Internet y un programa de navegación apropiado, y también el programa Adobe® Acrobat® Reader®. A menos que usted manifieste lo contrario a continuación, acepta recibir estas notificaciones legales con el certificado de seguro en forma electrónica por parte de su empleador. En cualquier momento, puede retirar su consentimiento y recibir una copia impresa de estas notificaciones legales llamando al 1-800-937-7039 o escribiendo a Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, FL 32224.

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[CERTIFICACIÓN, ENTENDIMIENTO Y AUTORIZACIONES

CERTIFICO que los enunciados y las respuestas provistos son efectuados por mí, son completos y verdaderos, han sido registrados correcta e íntegramente y que ninguna circunstancia o información importante ha sido retenida u omitida. Estos enunciados y respuestas se ofrecen a AHL a modo de inducción para la concesión de seguro, y entiendo que AHL podrá usar cualquier enunciado o declaración falsos para disputar la validez de cualquier cobertura provista sobre la base de esta Evidencia de Asegurabilidad (prueba de buen estado de salud) y Formulario de inscripción. • **AUTORIZO** a mi empleador a deducir de mi salario o sueldo la prima necesaria para las coberturas solicitadas. Entiendo que si rechazo cualquier cobertura para la cual soy elegible, se puede requerir prueba de asegurabilidad satisfactoria, por mi cuenta y cargo, en caso de que desee solicitarla en una fecha futura. Tal solicitud podría ser denegada sobre la base de dicha prueba.]

NOTIFICACIÓN SOBRE FRAUDE: Cualquier persona que, a sabiendas, presente un reclamación falsa o fraudulenta por el pago de una pérdida o beneficio o que, a sabiendas, presente información falsa en una solicitud de seguro será culpable de un crimen y podrá estar sujeta a multas y encarcelamiento.

Firma del asociado _____ Firmado en _____ Fecha de la firma _____
(Ciudad y estado)

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida
(the "Company")

Amendment No. 1 to Group Policy No. [G-12345]
issued to

[XYZ COMPANY, INC.]
(the "Policyholder")

It is hereby agreed that, effective [January 01, 2009], the Group Policy is amended as follows:

I.

-

-

-

-

-

-

This Amendment will be attached to and form a part of the Group Policy, and will not be held to alter or affect any of the terms of such Policy other than as specifically stated, but not unless both the Company and the Policyholder have executed this Amendment.

Signed on _____ Signed on _____
(Date) (Date)

**AMERICAN HERITAGE
LIFE INSURANCE COMPANY**
(the "Company")

(XYZ COMPANY, INC.)
(the "Policyholder")

by _____ by _____
(Signature of Officer) (Title) (Authorized Representative) (Title)



[Workplace Division]

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
[1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776]

A Stock Company

1

GROUP ACCIDENT INSURANCE POLICY WHICH INCLUDES ACCIDENTAL DEATH AND DISMEMBERMENT NON-PARTICIPATING

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this policy carefully and contact us promptly with any questions. This policy is delivered in and is governed by the laws of the governing jurisdiction, and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

1. all policy provisions and any amendments and/or attachments issued; and
2. the policyholder's signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

2

[]

Secretary

[]

President

**THIS IS A GROUP ACCIDENT POLICY WHICH ONLY PROVIDES BENEFITS FOR
OFF-THE-JOB ACCIDENTS AS DEFINED AND ON- AND OFF-THE-JOB ACCIDENT
INTENSIVE CARE UNIT BENEFIT AS DEFINED WITHIN THIS POLICY
AND OTHER BENEFITS SPECIFICALLY DESCRIBED HEREIN.
THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**

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LIMITATIONS AND EXCLUSIONS..... [10]

BENEFIT INFORMATION..... [11 – 15]

CLAIM INFORMATION [16 – 17]

GLOSSARY..... [18 – 20]

**GROUP ACCIDENT PLAN
WHICH INCLUDES ACCIDENTAL DEATH AND DISMEMBERMENT
POLICY SPECIFICATIONS**

- 4 **POLICYHOLDER:** [WALMART STORES, INC.]
- 5 **POLICY NUMBER:** [GROUP123]
- 6 **POLICY EFFECTIVE DATE:** [January 1, 2010]
- 7 **POLICY ANNIVERSARY DATE:** [January 1, 2011] and the [first day] of [January] each calendar year thereafter.
- GOVERNING JURISDICTION:** The state of Arkansas and subject to the laws of that jurisdiction.
- 8 **ELIGIBLE CLASS(ES):** [The classes of employees eligible for insurance are those classes defined in the policyholder's Health and Welfare Plan.]
- 9 **ELIGIBILITY WAITING PERIOD:** [The waiting period for eligible employees is as defined in the policyholder's Health and Welfare Plan]
- 10 **INITIAL RATE:** [Bi-weekly rate of \$XX.XX per employee for Employee-Only Coverage; or \$XX.XX per employee for Employee and Child(ren) Coverage; \$XX.XX per employee for Employee and Spouse Coverage; or \$XX.XX per employee for Family Coverage]
- 11 **RATE GUARANTEE DATE:** [12/31/2016 for active employees]
- 12 **PREMIUM DUE:** [01/01/2010 and bi-weekly thereafter.] The policyholder must send all premiums on or before the premium due date to us. The premium must be paid in United States dollars.
- 13 **COST OF COVERAGE:** [The employee pays the cost of coverage pre-tax through the policyholder's Flexible Benefit Plan.]
- 14 **[DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES**

These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

Name

Location (City and State)]

[None]

POLICYHOLDER PROVISIONS

RATE GUARANTEE

A change in premium rate will not take effect before the Rate Guarantee Date shown on page 3, except for the following reasons:

1. a change occurs in this plan design (including any material change in the eligibility rules) that is requested by the policyholder; or
- 15 2. the number of insured eligible employees decreases by [50%] or more due to corporate restructuring; or
3. a new law or a change in any existing law is enacted which applies to this policy that would materially change the cost of the policy.

We will notify the policyholder in writing at least [180 days] before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree in writing.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases may take effect any time subject to the "Rate Guarantee" provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

INFORMATION REQUIRED FROM THE POLICYHOLDER

The policyholder must provide us with the following on a regular basis:

1. information about employees:
 - a. who are eligible to become insured; and
 - b. whose coverage changes; and/or
 - c. whose coverage ends; and
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required to administer this policy.

CANCELING POLICY

This policy can be canceled:

1. by us; or
2. by the policyholder.

16 We may terminate or offer to modify this policy after the Rate Guarantee Date with at least [365 days] written notice to the policyholder, if:

1. the policyholder fails to perform any of its material obligations that relate to this policy; or
2. fewer than [50 employees] are insured.

With regards to the policyholder's failure to perform any of its material obligations that relate to this policy, before we give the policyholder [365 days] written notice of our intent to terminate or modify this policy, we must first give the policyholder [30 days] written notice of the breach and the opportunity to cure the breach during that [30 day] period. Only after giving such notice may we provide the policyholder with the [365 days] written notice of our intent to terminate or modify this policy.

The policyholder must pay us all premiums due for the full period this policy is in force. If the premium is not paid before the grace period ends, we may terminate this policy with at least [30 days] written notice to the policyholder. If the policyholder pays all past due premiums before the conclusion of the [30 day] notice period, the policy will not terminate.

The policyholder may cancel this policy by written notice delivered to us at least [180 days] prior to the cancellation date. When both the policyholder and we agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

GENERAL PROVISIONS

ELIGIBILITY OF DEPENDENTS

Eligible dependents are the individuals defined as "Eligible Dependents" under the policyholder's Health and Welfare Plan.

Dependents of an employee cannot be covered as both a dependent and as an employee with their own coverage. If a dependent is or becomes covered as an employee with their own coverage, we will terminate their coverage as a dependent and refund any premium that may have been paid for the dependent coverage for the period of time that they were covered as a dependent while having their own coverage.

A child born to the employee or spouse, while Employee and Child(ren) Coverage or Family Coverage is in force, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for other dependent children covered under this policy.

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If the insured employee has Employee-Only Coverage [or Employee and Spouse Coverage], newborn children are automatically covered from the moment of birth for a period of [60 days]. If the insured employee desires uninterrupted coverage for a newborn child, the insured employee must notify the employer within [60 days] of that child's birth. Upon notification to us, we will convert the insured employee's Employee-Only Coverage to Employee and Child(ren) Coverage [or Employee and Spouse Coverage to Family Coverage] and provide notification of the additional premium due. If the insured employee does not notify the employer within [60 days] of the birth of the child, the temporary automatic coverage ends.

If the insured employee has Employee-Only Coverage or Employee and Child(ren) Coverage and marries and desires coverage for his or her spouse, the insured employee must notify the employer of the marriage within [60 days] of the marriage. We will convert the coverage to Employee and Spouse Coverage or Family Coverage and provide notification of the additional premium due.

An adopted child or child pending adoption will be covered as follows:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by the insured employee has been entered within [60 days] after the date of birth.
2. If adoption proceedings have been instituted by the insured employee within [60 days] after the date of birth and the insured employee has temporary custody, coverage is provided from the moment of birth.
3. For children other than newborns, if adoption proceedings have been completed, and a decree of adoption was entered within 1 year from the institution of the proceedings, coverage will begin upon temporary custody for 1 year, unless extended by the order of the court by reasons of the special needs of the child.

Coverage must be provided as long as the insured employee has custody of the child pursuant to decree of the court and required premiums are paid.

If the insured employee has Employee-Only Coverage [or Employee and Spouse Coverage], we will convert the Employee-Only Coverage to Employee and Child(ren) Coverage [or Employee and Spouse Coverage to Family Coverage] and provide notification of the additional premium due.

ELIGIBILITY DATE

If the employee is working for the policyholder in an eligible class, the date such employee is eligible for coverage is the later of:

1. the policy effective date; or
2. the date that the employee becomes eligible for coverage under the terms of the policyholder's Health and Welfare Plan.

WHEN AN ELIGIBLE EMPLOYEE CAN ENROLL FOR OR CHANGE COVERAGE

The employee may apply for or change coverage as permitted under the terms of the policyholder's Health and Welfare Plan.

GENERAL PROVISIONS (Continued)

EFFECTIVE DATE OF COVERAGE

Coverage for employees who enroll during the initial enrollment will be effective on the effective date of this policy. For employees who enroll subsequent to the effective date of this policy, coverage will be effective in accordance with the terms of the policyholder's Health and Welfare Plan.

For any change in an employee's coverage, the change in coverage is effective in accordance with the terms of the policyholder's Health and Welfare Plan.

CERTIFICATES OF INSURANCE

We will furnish to the policyholder a certificate of insurance for delivery to each insured employee. The certificate will provide a description of the insurance provided by this policy and will state:

1. the essential features of the insurance coverage; and
2. to whom benefits are payable.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

TERMINATION OF COVERAGE

The insured employee's coverage under this policy ends, subject to the "Portability Coverage" provision of this policy, on the earliest of:

1. the date this policy is canceled by the policyholder; or
2. the last day of the period for which such insured employee made any required premium payments; or
3. the last day such insured employee is in active employment, except as provided under the "Leave of Absence" provision; or
4. the date such insured employee is no longer in an eligible class; or
5. the date such insured employee's class is no longer eligible.

We will provide coverage for a payable claim that occurs while the insured employee is covered under this policy.

If the insured employee's spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or death of the insured employee, or when an insured employee moves to an eligible class that does not provide spouse coverage.

Coverage for a dependent child ends on the certificate anniversary next following the date the child is no longer eligible for coverage under the terms of the policyholder's Health and Welfare Plan. Coverage does not terminate for an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under this policy; and
3. is chiefly dependent upon the insured employee for support and maintenance.

The child's coverage continues as long as the insured employee's coverage remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished to us when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims incurred after termination will not be paid. There may be no refund due if the insured employee has Employee and Child(ren) Coverage or Family Coverage and there are other eligible dependents insured under this policy.

Coverage may be eligible for continuation as outlined in the "Portability Coverage" provision.

AGENCY

For purposes of this policy, the policyholder acts on its own behalf or as the employee's agent. Under no circumstances will the policyholder be deemed our agent.

GENERAL PROVISIONS (Continued)

LEAVE OF ABSENCE

If an insured employee ceases active employment because of a leave of absence while coverage is in force, he or she will have the opportunity to continue coverage while he or she is away from active employment. Coverage will be in accordance with the terms of the policyholder's Health and Welfare Plan. This includes, but is not limited to, how coverage is provided, how premiums are paid for during the absence, and whether coverage is reinstated upon return to employment.

GRACE PERIOD

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The policyholder is entitled to a grace period of [60 days] for the payment of any premium due. This policy continues in force during the grace period, unless the policyholder gives us written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of this policy. The policyholder is liable to us for the payment of any pro-rata premium for the time this policy is in force during a grace period.

ENTIRE CONTRACT

The contract consists of the following items:

1. the group policy; and
2. any amendments and endorsements; and
3. the application and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the insured employee.

Any statements made by the policyholder or by a covered person, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or the covered person will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his or her beneficiary, if any, if a claim is denied based upon such a statement.

INCONTESTABILITY

After 2 years from the effective date of this policy, no misstatement of the policyholder, made in any applications, can be used to void this policy. After 2 years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim.

19 [DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of this policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of this policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of this policy, such determinations shall be final and conclusive.]

LEGAL ACTION

No legal action may be brought to obtain benefits under this policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 180 days from the time a decision on appeal regarding a claim for benefits under this policy has been rendered. A lawsuit may not be filed after this 180 day period expires.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder documenting any clerical errors.

GENERAL PROVISIONS (Continued)

BENEFICIARY; CHANGE OF BENEFICIARY

If there is no named beneficiary, we will pay any benefits due at a covered person's death in the following order:

- 20
1. [to the insured employee, if living; otherwise
 2. to the insured employee's spouse, if living; otherwise
 3. to the covered person's children, in equal shares, if living; otherwise
 4. to the covered person's parents, in equal shares, if living; otherwise
 5. to the covered person's siblings, in equal shares, if living; otherwise
 6. to the covered person's estate].

Any change of beneficiary must be filed with the policyholder or at our home office. It will not take effect unless so filed, but if so filed, will take effect on the date signed. This will be true whether or not the covered person is living on the date it is filed. There will be no prejudice to us on account of any payment we make prior to its receipt by us at our home office.

21 [UNPAID PREMIUM; EXCESS PREMIUM

Upon the payment of a claim under this policy, any premium owed by an employee in an individual capacity that is more than [60 days] past due may be deducted from the benefit amount payable to the employee. Any excess premium will be refunded to the employee.]

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PORTABILITY COVERAGE

We will provide portability coverage, subject to these provisions.

Such coverage will be available for a covered person, if the following criteria are satisfied:

1. coverage under this policy terminates as described in the General Provision entitled "Termination of Coverage"; and
2. we receive a request for portability and payment of the first premium for the portability coverage not later than [60 days] after such termination.

No portability coverage will be provided for any person, if his or her insurance under this policy terminated due to his or her failure to make required premium payments.

PORTABILITY COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under this policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under this policy. Any change made to this policy after a covered person is insured under the portability coverage will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after a covered person's coverage under this policy terminates.

PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance of each month of coverage to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate for the first [36 months] of portability coverage is the rate in effect under this policy for active employees who have the same coverage. After the first [36 months], the premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least [31 days] before any change is to take effect.

GRACE PERIOD

The grace period, as defined in this policy, will apply to each certificate holder of portability coverage as if such covered person is the policyholder.

TERMINATION OF PORTABILITY COVERAGE

Insurance under this portability coverage will automatically end on the earliest of the following dates:

1. the date the person again becomes eligible for insurance under this policy; or
2. the last day for which premiums have been paid, if the covered person fails to pay premiums when due, subject to the grace period; or
3. with respect to insurance for dependents:
 - a. the date the employee's insurance terminates; or
 - b. the date the dependent ceases to be an eligible dependent, as defined.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

TERMINATION OF THE POLICY

If this policy terminates, insured employees and their covered dependents will be eligible to exercise the portability privilege on the termination date of this policy. Portability coverage may continue beyond the termination date of this policy, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if this policy had remained in full force and effect.

LIMITATIONS AND EXCLUSIONS

This policy does not cover any loss incurred by a covered person as a result of:

1. an injury that occurred as the result of an on-the-job accident, except as may be provided under the On- and Off-the-Job Accident Only Intensive Care Unit Benefit; or
2. injury incurred prior to the covered person's effective date of coverage subject to the Incontestability provision; or
3. any act of war whether or not declared, participation in a riot, insurrection or rebellion; or
4. suicide, or any attempt at suicide, whether sane or insane; or
5. any injury sustained while the covered person is under the influence of alcohol or any narcotic, unless administered upon the advice of a physician; or
- ~~6. hernia, including any complications due to hernia; or~~
7. dental or plastic surgery for cosmetic purposes except when such surgery is required to treat an injury or correct a disorder of normal bodily function that was caused by an injury; or
8. participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or
9. committing or attempting to commit an assault or felony; or
10. driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway.

Any injury incurred while a covered person is an active member of the Military; Naval; or Air Forces of any country or combination of countries is not covered. Upon notice and proof of service in such forces, we will return the pro-rata portion of the premium paid for any period of such service.

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BENEFIT INFORMATION

OFF-THE-JOB ACCIDENT ONLY BENEFITS

If, while this policy is in force, a covered person sustains an injury caused by an off-the-job accident which results in any of the losses stated in this "Benefit Information" provision, and is diagnosed by a physician, we pay the following benefits for such loss. ~~Unless otherwise specified, if a loss is eligible to be paid under more than 1 benefit, the highest eligible benefit will be paid.~~ Any loss not stated in this "Benefit Information" provision is not covered under this policy.

- A. Emergency Treatment:** We pay \$120 for the insured employee or covered spouse and \$70 for a covered child for required medical treatment as a result of a covered accident. This benefit is payable for physician fees, x-rays, and emergency room services. Treatment must be received within 72 hours of the covered accident. This benefit is payable only once for any and all treatment that occurs during any 24-hour period, per covered person, per covered accident.
- B. Follow-Up Treatment:** We pay \$25 per follow-up visit when a covered person requires additional follow-up treatment after receiving emergency treatment for which a benefit is paid under Emergency Treatment (benefit A). Follow-up treatment must be administered by a physician in a physician's office or in a hospital on an outpatient basis. Follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital. This benefit is payable for 1 follow-up treatment per day for a maximum of 6 treatments, per covered person, per covered accident. This benefit is not payable for treatments for which the Physical Therapy benefit (benefit R) is paid.
- C. Initial Hospitalization:** We pay \$1,000 the first time a covered person is hospital confined for at least 24 hours for treatment as a result of an injury; or \$1,500 if the covered person is admitted directly to a hospital intensive care unit. Confinement must start within 30 days of the covered accident. This benefit is payable only once per continuous hospital or intensive care unit confinement, per calendar year, per covered person.
- D. Hospital Confinement:** We pay a daily benefit of \$200 for a continuous hospital confinement, up to 365 days per covered accident, when a covered person is hospital confined for at least 18 hours for treatment as a result of an injury. Confinement must start within 30 days of the covered accident. This benefit is not payable for days on which the Rehabilitation benefit (benefit S) is paid. This benefit is paid in addition to the Initial Hospitalization benefit (benefit C).
- E. Intensive Care Unit Confinement:** We pay a daily benefit of \$400, up to 15 days for any 1 accident, per covered person, when a covered person is confined in a hospital intensive care unit, as a result of an injury. This benefit is paid in addition to the Initial Hospitalization benefit (benefit C) and the Hospital Confinement benefit (benefit D). Confinement must start within 30 days of the covered accident.
- F. Dislocation:** We pay the benefit amount shown in the chart below when a covered person sustains a dislocation as a result of a covered accident. This benefit is payable for only the first dislocation of a joint. If a covered dislocation is reduced with local anesthesia or no anesthesia by a physician, we will pay 25% of the benefit amount shown in the chart below. This benefit is payable for a maximum of 2 covered dislocations per covered person, per covered accident. ~~If more than 2 dislocations occur during a covered accident, we will pay benefits for the 2 dislocations with the largest dollar amount benefits.~~

<u>Joint</u>	<u>Benefit Amount</u>
Hip	\$2,000
Collar bone	\$800
Knee or shoulder	\$500
Ankle or foot (excluding toes)	\$500
Lower jaw	\$500
Wrist or elbow	\$400
Toe or finger	\$100

BENEFIT INFORMATION (Continued)

OFF-THE-JOB ACCIDENT ONLY BENEFITS (Continued)

- G. Burns:** We pay the benefit amount shown in the chart below when a covered person sustains a burn as a result of an accident if treated by a physician within 72 hours after a covered accident. Injuries due to sunburn are not a covered benefit.

<u>Affected Area</u>	<u>Benefit Amount</u>	
	<u>2nd Degree</u>	<u>3rd Degree</u>
1 though 19 Less than 20 square centimeters of the body surface	\$100	\$200
More than 20 but less than 40 through 39 square centimeters of the body surface	\$200	\$500
More than 40 but less than 65 square centimeters of the body surface	\$400	\$1,000
More than 65 but less than 160 square centimeters of the body surface	\$600	\$3,000
More than 160 but less than 225 square centimeters of the body surface	\$800	\$7,000
More than 225 square centimeters of the body surface	\$1,000	\$10,000

If the proof of loss does not specify the size of the burn, the lowest benefit amount shown will be paid.

- H. Skin Grafts:** We pay 50% of the benefit amount paid under the Burns benefit (benefit G) if a covered person receives 1 or more skin grafts for a covered burn. This benefit is paid in addition to the Burns benefit (benefit G).

- I. Eye Injury:** We pay \$250 for surgical repair or \$50 for removal of a foreign body by a physician if a covered person sustains an eye injury as a result of a covered accident.

- J. Lacerations:** We pay the benefit amount shown in the chart below when a covered person receives treatment for lacerations within 72 hours after a covered accident.

<u>Laceration</u>	<u>Benefit Amount</u>
Laceration(s) not requiring sutures	\$25
Single laceration less than 5 centimeters	\$50
Laceration(s) at least 5 centimeters but not more than 15 centimeters (total of all lacerations)	\$200
Laceration(s) over 15 centimeters (total of all lacerations)	\$400

If the proof of loss does not specify the size of the laceration, the lowest benefit amount shown will be paid.

- K. Fractures:** We pay the benefit amount shown in the chart below when a covered person sustains a fracture corrected by open or closed repair as a result of a covered accident. This benefit is payable for no more than 2 fractures per covered person, per covered accident. **If more than 2 fractures occur during a covered accident, we will pay benefits for the 2 fractures with the largest dollar amount benefits.**

<u>Fracture</u>	<u>Benefit Amount</u>
Hip	\$2,000
Skull	
depressed	\$1,500
simple	\$500
Leg	\$1,000
Rib	\$1,000
Vertebrae (body of), pelvis (excluding coccyx), or sternum	\$1,000
Vertebral processes	\$1,000
Upper jaw, upper arm, or face (excluding nose)	\$600
Hand (excluding fingers)	\$500
Foot (excluding toes/heel)	\$500
Lower jaw	\$500
Nose, heel, or finger	\$500
Shoulder blade or forearm	\$500
Wrist, elbow, ankle, or kneecap	\$500
Coccyx	\$200
Toe	\$200

We pay 25% of the amounts shown for chip fractures or other fractures not corrected by open or closed repair.

BENEFIT INFORMATION (Continued)

OFF-THE-JOB ACCIDENT ONLY BENEFITS (Continued)

- L. Emergency Dental Services:** We pay the benefit amount shown in the chart below when a covered person receives dental services as a result of an injury. This benefit is payable for no more than 1 dental benefit per covered person, per covered accident.

<u>Dental Service</u>	<u>Benefit Amount</u>
Broken teeth repaired with crowns	\$150
Broken teeth resulting in extractions	\$50

- M. Coma:** We pay \$10,000 if a covered person is in a coma as a result of a covered accident.

- N. Brain Concussion:** We pay \$50 if a covered person sustains a concussion as a result of a covered accident.

- O. Paralysis:** We pay the benefit amount shown in the chart below if a covered person suffers from spinal cord injury received in a covered accident which results in a complete and total loss of use of 2 or more limbs. Paralysis must last 30 or more consecutive days and must be confirmed by a physician. This benefit is only payable once per covered person.

<u>Paralysis</u>	<u>Benefit Amount</u>
Quadriplegia (Paralysis of 4 limbs)	\$10,000
Paraplegia (Paralysis of lower 2 limbs)	\$5,000

- P. Surgical Procedures:** We pay the benefit amount shown in the chart below if a covered person requires a surgical procedure as a result of a covered accident. Two or more surgical procedures performed through the same incision or entry point are considered 1 operation; we pay the amount for the procedure with the largest dollar amount benefit. Surgery must be performed within 1 year of a covered accident. Miscellaneous surgery is surgery that requires general anesthesia and is not covered by any other specific surgery benefit listed below. The miscellaneous surgery benefit is payable only once per 24 hour period even though more than 1 surgery or procedure may be performed.

<u>Surgery</u>	<u>Benefit Amount</u>
Open abdominal (including exploratory laparotomy), cranial, hernia, or thoracic surgery	\$1,000
Ruptured discs	\$500
Tendons and/or ligaments	\$500
Torn knee cartilages	\$500
Torn rotator cuffs	\$500
Arthroscopy without surgical repair	\$250
Miscellaneous surgery	\$250

- Q. Major Diagnostic Exams:** We pay \$150 if a covered person requires 1 of the following exams as a result of a covered injury: CT (computerized tomography) scan; MRI (magnetic resonance imaging); or EEG (electroencephalogram). The exam must be performed in a hospital, a physician's office, or an ambulatory surgical center. This benefit is limited to 1 payment per calendar year, per covered person.

- R. Physical Therapy:** We pay \$25 per day for physical therapy if a covered person receives physical therapy as a result of a covered injury. Therapy must be prescribed by a physician and begin within 30 days of the covered accident or discharge from the hospital and be received within the first 6 months after the covered accident or discharge from the hospital. This benefit is payable for 1 treatment per day for a maximum of 10 treatments per covered accident, per covered person. This benefit is not payable for treatments which the Follow-Up Treatment benefit (benefit B) is paid.

- S. Rehabilitation:** We pay \$100 per day if a covered person is confined to a rehabilitation unit as a result of a covered accident, provided that the covered person has been confined to a hospital immediately prior to being transferred to the rehabilitation unit. This benefit is paid for each day a room charge is incurred, up to 30 days for each covered person per continuous period of rehabilitation unit confinement, for a maximum of 60 days per calendar year. This benefit is not payable for days in which the Hospital Confinement benefit (benefit D) is paid.

BENEFIT INFORMATION (Continued)

OFF-THE-JOB ACCIDENT ONLY BENEFITS (Continued)

- T. Appliances:** We pay \$100 if a covered person, as a result of a covered injury and upon the advice of a physician, requires the use of a medical appliance as an aid in personal locomotion or mobility. Covered medical appliances are: crutches; wheelchair; leg brace; back brace; and walker. This benefit is payable only once per covered person, per covered accident.
- U. Prosthesis:** We pay \$500 if a covered person requires a prosthetic device as a result of a covered injury. This benefit is not payable for hearing aids, wigs, or any dental aids including false teeth. This benefit is payable only once per covered person, per covered accident.
- V. Blood, Plasma and/or Platelets:** We pay \$100 if a covered person, as a result of a covered injury, requires blood, plasma, and/or platelets. This benefit is not payable for immunoglobulins and is payable only once per covered person, per covered accident.
- W. Ambulance:** We pay \$150 for ground ambulance or \$1,000 for air ambulance if a covered person requires ambulance transportation to a hospital or emergency center as a result of a covered injury. The ambulance transportation must occur within 72 hours of the covered accident. Service must be provided by a licensed professional ambulance company.
- X. Transportation:** We pay \$400 per round trip for treatment at a non-local hospital as the result of a covered accident. This benefit is payable for only the covered person for whom the treatment is prescribed, except that if the treatment is for a covered dependent child and travel by common carrier is necessary, we pay an additional \$400 per round trip for 1 of the dependent child's parents or legal guardians to travel with the child. A physician must prescribe the treatment. This benefit is payable for up to 3 round trips per calendar year, per covered person. This benefit is not payable for transportation by ambulance or air ambulance to the hospital.
- Y. Family Lodging:** We pay \$100 per night for 1 motel/hotel room for an immediate family member to accompany the covered person who requires non-local hospital confinement as a result of a covered accident. This benefit is payable for up to 30 days per covered accident, and only during the days the covered person is confined in the hospital.
- Z. Accidental Death and Dismemberment:** We pay the benefit amount shown in the chart below if death or dismemberment occurs as a result of an injury sustained in a covered accident within 90 days of such accident. If more than 1 dismemberment is sustained in any 1 accident, the total amount we will pay will not exceed the highest single benefit for accidental dismemberment. Benefits are payable only once for any covered accident. If death and dismemberment result from the same accident, only the Accidental Death benefit will be paid. This benefit is paid regardless of whether the dismembered body part is surgically reattached.

<u>Accidental Death</u>	<u>Common Carrier</u>	<u>Other Accidents</u>			
Insured Employee:	\$100,000	\$25,000			
Covered Spouse:	\$100,000	\$25,000			
Covered Child:	\$15,000	\$7,500			

<u>Accidental Dismemberment</u>	<u>Both arms and both legs</u>	<u>2 eyes, feet, hands, arms or legs</u>	<u>1 eye, foot, hand, arm or leg</u>	<u>1 or more fingers and/or 1 or more toes</u>
Insured Employee:	\$25,000	\$25,000	\$6,250	\$1,250
Covered Spouse:	\$25,000	\$25,000	\$6,250	\$1,250
Covered Child:	\$7,500	\$7,500	\$1,875	\$500

BENEFIT INFORMATION (Continued)

ON- AND OFF-THE-JOB ACCIDENT ONLY INTENSIVE CARE UNIT BENEFIT

- A. Intensive Care Unit:** We pay a daily benefit of \$600 when a covered person is confined to an intensive care unit for at least 18 hours as a result of an injury from a covered on-the-job accident. This benefit is payable for up to 15 days per covered person, per covered accident. Confinement must start within 30 days of the accident.
- B. Step-down Intensive Care Unit Confinement:** We pay a daily benefit of \$200 for an off-the-job accident or \$400 for an on-the-job accident when a covered person is confined to a step-down intensive care unit for at least 18 hours as a result of an injury sustained from a covered accident. This benefit is payable in addition to any Hospital Confinement benefit (benefit D) payable for a covered accident. This benefit is payable for up to 15 days per covered person, per covered accident.

WELLNESS BENEFIT

23 Wellness: We pay [\$75] per certificate year, for either the insured employee or 1 other covered person, when an eligible examination or test is performed, after the insured employee's coverage has been in force for at least 12 months. The test must be performed under the supervision of or recommended by a physician, while coverage is in force, and a charge must be incurred. We will pay this benefit regardless of the result of the examination or test. The eligible wellness examinations and tests are:

1. [annual physical examination; and
2. dental examination; and
3. mammography; and
4. pap smear; and
5. eye examination; and
6. immunization; and
7. flexible sigmoidoscopy; and
8. PSA (prostate specific antigen – blood test for prostate cancer); and
9. ultrasound; and
10. blood screening].

[If the employee was insured by the prior accident policy offered through the policyholder's Health and Welfare Plan, the length of time his or her coverage was in effect will reduce the waiting period for receiving benefits under this wellness benefit.]

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CLAIM INFORMATION

NOTICE OF CLAIM

24

We encourage a covered person to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim must be given to us within 60 days after the occurrence or commencement of any loss covered by this policy, or as soon as reasonably possible. Notice given to us by, or on behalf of, a covered person or the beneficiary to us at [PO Box 41488, Jacksonville FL 32203-1488], with the covered person's name and certificate number, is notice to us.

A claim form can be requested from us. If it is not received within 15 days of the request, notice of claim may be sent to us by providing us a statement of the nature and extent of the loss.

FILING A CLAIM

25

[If a covered person's claim is denied, a notice will be sent within a reasonable time period, but not longer than 90 days from receipt of the claim. If we determine that an extension is necessary due to special circumstances, this time may be extended for an additional 90 days. A covered person will receive notice before the extension that indicates the special circumstances requiring the extension and the date by which we expect to render a determination.

If the claim is in part or wholly denied, the covered person will receive notice of an adverse benefit determination that will:

- state the specific reason(s) for the adverse benefit determination; and
- reference the specific policy provisions on which the determination is based; and
- describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary; and
- describe the policy's claims review procedures and the time limits applicable to such procedures, including a statement of the covered person's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.]

PROOF OF CLAIM

Written proof must be given to us within 90 days of each loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 15 months from the time specified unless the covered person is legally incapacitated.

COOPERATION OF BENEFICIARY

The beneficiary must reasonably cooperate during any investigation and/or adjudication of a claim. This includes the authorization for the release of medical records and other information.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have any covered person examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of contestability, where it is not forbidden by law.

PAYMENT OF CLAIMS

After receiving written proof of loss, we will pay all benefits then due under this policy and will make payment to the insured employee, unless the insured employee assigned the benefit to someone else. Any amounts unpaid at the insured employee's death may, at our option, be paid either to the named beneficiary or as described in the "Beneficiary; Change of Beneficiary" provision.

ASSIGNMENT

An assignment of the coverage under this policy is not binding on us, unless:

1. it is a written request; and
2. it is received and recorded by us at our home office.

We are not responsible for the validity of any assignment. An assignment is subject to any payment we make or other action we take before we record the assignment. An assignment may not change the owner or beneficiary.

CLAIM INFORMATION (Continued)

OVERPAID CLAIM

We have the right to recover any overpayments due to:

1. fraud; or
2. any error we make in processing a claim.

The insured employee must reimburse us in full. We will work with such insured employee to develop a reasonable method of repayment if he or she is financially unable to repay us in a lump sum.

We will not recover more money than we overpaid.

CLAIM REVIEW

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[A covered person will have 60 days from the receipt of an adverse benefit determination to file an appeal. Requests for appeals should be sent to [Allstate Workplace Division, Wal-Mart Claims Unit, PO Box 41488, Jacksonville FL 32203-1488], Attention: Appeals.

A covered person will have the opportunity to submit written comments, documents, or other information in support of the appeal, and the covered person will have access to all documents that are relevant to the claim.

The covered person will be notified of our benefit determination on review within a reasonable time, but not later than 60 days from receipt of the request for review. If we determine that an extension is necessary due to special circumstances, this time may be extended for an additional 60 days. The covered person will receive notice before the extension that indicates the special circumstances requiring the extension and the date by which we expect to render a determination.

If the claim is in part or wholly denied, the covered person will receive notice of an adverse benefit determination that will:

- state specific reason(s) of the adverse determination;
- reference specific policy provision(s) on which the benefit determination is based;
- state that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- describe any voluntary appeal procedures offered by the policy and the covered person's right to obtain information about such procedures; and
- include a statement regarding the covered person's right to bring an action under section 502(a) of ERISA.]

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GLOSSARY

Active Employment. Means that the employee is working for the employer for earnings that are paid regularly and is performing the material and substantial duties as assigned by the employer. The employee will be deemed to be in active employment on a day which is not one of the employer's scheduled work days only if actively employed on the preceding scheduled work day. Temporary and seasonal workers are excluded from coverage.

The location at which the employee performs work must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the job requires such employee to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment.

Calendar Year. Means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

Certificate Year. Means a consecutive 12 month period beginning on the effective date of insurance for each insured employee.

Coma. Means a continuous state of profound unconsciousness which lasts 7 or more consecutive days as a result of a covered accident. A coma is characterized by an absence of spontaneous eye movements, response to painful stimuli and vocalization. The condition must require intubation for respiratory assistance. Medically induced comas are excluded.

Common Carrier. Means only the following: commercial airlines; passenger trains; inter-city buslines; trolleys; or boats. It does not include taxis; intra-city buslines or private charter planes.

Continuous Hospital Confinement. Means 1 continuous confinement or 2 or more hospital confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Covered Accident. Means a sudden, unforeseen and unexpected event which occurs without the covered person's intent, which results in an injury to the covered person and for which benefits are payable.

Covered Person. Means any of the following:

1. any eligible family member (including the employee) named in the enrollment or evidence of insurability form and acceptable for coverage by us; or
2. any eligible dependent added after the effective date; or
3. a newborn child or adopted child subject to the "Eligibility of Dependents" provision.

Day. A 24 hour period.

Eligibility Waiting Period. Means the continuous period of time that the employee must be in active employment in an eligible class before he or she is eligible for coverage.

Employee. Means a person who is: (1) a citizen or resident of the United States or one of its territories; and (2) in active employment with the employer named as the policyholder.

Employee and Child(ren) Coverage. Means coverage that includes only the insured employee, as defined, and eligible children.

[Employee and Spouse Coverage. Means coverage that includes only the insured employee, as defined, and his or her spouse.]

Employee-Only Coverage. Means coverage that includes only the insured employee, as defined.

GLOSSARY (Continued)

Employer. Means the individual, company or corporation where the employee is in active employment, and includes any division, subsidiary, or affiliated company named in this policy.

Family Coverage. Means coverage that includes the insured employee, as defined, and his or her eligible dependents.

Fracture. Means a break in a bone that can be seen by x-ray and can be corrected by open (surgical) or closed (manipulative) repair.

27 **Grace Period.** Means a period of [60 days] following the premium due date during which premium payment may be made. While the insured employee is employed with the policyholder, the premiums will be paid by the policyholder through payroll deductions. The grace period only applies to the insured employee during any portability period, when the insured employee will be required to pay the premiums directly to us.

Hospital. Means a legally operated institution with established facilities (either on its premises or available to the hospital on a contractual, pre-arranged basis and under the supervision of a staff of 1 or more duly licensed physicians), for the care and treatment of sick and injured persons for diagnosis, surgery, and 24 hour nursing service. Hospital does not include:

1. any institution which is mainly a rest home, nursing home, convalescent home, or home for the aged; or
2. any institution which is mainly for the care and treatment of alcoholics or drug addicts, or mental or nervous disorders.

Hospital Confined or Confinement. Means confinement as an inpatient in a hospital for which a room and board charge is made by the hospital. It does not include confinement for an observation room or a fractional part of a day.

Hospital Intensive Care Unit. Means a hospital area of special care, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds, or wards normally used for patient confinement. In addition, the unit must provide the following:

1. 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis; and
2. direction and/or supervision by a full-time physician director or a standing "intensive care" committee of the medical staff; and
3. special medical apparatus used to treat the critically ill.

Hospital Intensive Care Unit Confinement. Means 1 continuous confinement or 2 or more hospital intensive care unit confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Immediate Family Member. Means spouse, mother, father, child, step-child, adopted child.

Injury. Means a bodily injury caused directly by an accident, independent of sickness, disease, bodily infirmity, or any other cause, occurring on or after the effective date of coverage and while coverage is in force. See the Limitations and Exclusions section for injuries not covered by this policy.

Inpatient. Means a covered person who is a resident patient using the room and board facilities of a hospital.

Insured Employee. Means an employee who has: (1) fulfilled all eligibility requirements set forth in this policy and the policyholder's Health and Welfare Plan; and (2) properly completed and signed the enrollment, provided that the enrollment has been received by us.

Leave of Absence. Means the employee is absent from active employment for a period of time that has been agreed to in advance in writing by the current employer.

Normal vacation time or any period of disability is not considered a leave of absence.

Non-local. Means more than 100 miles from the covered person's home or site of the accident.

GLOSSARY (Continued)

Nurse. Means any one of the following who is not a member of the covered person's immediate family or employed by the hospital where the covered person is confined:

1. licensed practical nurse (L.P.N.); or
2. licensed vocational nurse (L.V.N.); or
3. graduate registered nurse (R.N.).

Off-the-Job Accident. Means an accident that occurs while a covered person is not working at any job for pay or benefits.

On-the-Job Accident. Means an accident that occurs while a covered person is working at any job for pay or benefits.

Paralysis. Means spinal cord injuries received in a covered accident that result in complete and permanent loss of function of 2 or more limbs for a period of not less than 30 days. Paralysis must be confirmed by the attending physician.

Payable Claim. Means a claim for which we are liable under the terms of this policy.

Physician. Means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the state he or she practices in.

We will not recognize the insured employee, his or her spouse, children, parents, or siblings as a physician for a claim.

Policyholder. Means the legal entity to whom this policy is issued.

Rehabilitation Unit. Means a hospital area providing coordinated multi-disciplinary physical restorative services to inpatients under the direction of a physician who is knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

Step-down Intensive Care Unit. Means a hospital area of special care, which provides a level of medical care below the highest level of acute medical care available at the hospital, but above the level of medical care in a regular private or semiprivate room or ward. The facility is separate and apart from the surgical recovery room, other rooms, beds, or wards normally used for patient confinement. In addition, the unit must provide 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis.

Under the Influence. Means a condition as determined by the laws of the state in which the loss occurred.

We, Us and Our. Means American Heritage Life Insurance Company.

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Allstate[®]

Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224-6687

(904) 992-1776

A Stock Company

**THIS IS A GROUP ACCIDENT POLICY WHICH ONLY PROVIDES BENEFITS FOR
OFF-THE-JOB ACCIDENTS AS DEFINED AND ON- AND OFF-THE-JOB ACCIDENT
INTENSIVE CARE UNIT BENEFIT AS DEFINED WITHIN THIS POLICY
AND OTHER BENEFITS SPECIFICALLY DESCRIBED HEREIN.
THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**



[Workplace Division]

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
[1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776]

A Stock Company

1

(called "we", "our", "us" or "Company")

CERTIFICATE OF INSURANCE

This certificate explains the policy of insurance underwritten by us. It is not the contract of insurance. The policy (called the "policy"), as issued to the policyholder by us, alone makes up the agreement under which insurance coverage is provided and benefits are determined. The policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. The policy may be inspected at the office of the policyholder during normal business hours.

The accident coverage under this policy is a benefit offered as part of the Associates' Health and Welfare Plan (Plan). The Plan is an employer-sponsored health and welfare employee benefit plan governed under ERISA.

This document, together with the current version of the Associate Benefits Book, constitutes the summary plan description (SPD) for the accident coverage portion of the Plan. The SPD, together with the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan Wrap Document, are the Plan documents for the Plan.

As a summary, this SPD does not describe every provision of the controlling Plan, nor does it modify any provision of the applicable Plan documents.

CONSIDERATION

Your coverage under the policy is issued to you in consideration of your enrollment form or other form of application and the payment of the first premium. Your coverage under the policy is effective from 12:01 a.m. Standard Time on your effective date.

INSURING CLAUSE

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due. All such coverage is subject to the terms of the policy.

In this certificate the insured certificate holder (associate) will be referred to as "you", "your" or "yours".

This certificate supersedes and replaces any certificate previously issued to you under the policy.

2

[]

Secretary

[]

President

THIS IS A GROUP ACCIDENT CERTIFICATE WHICH ONLY PROVIDES BENEFITS FOR OFF-THE-JOB ACCIDENTS AS DEFINED AND ON- AND OFF-THE-JOB ACCIDENT INTENSIVE CARE UNIT BENEFIT AS DEFINED WITHIN THIS CERTIFICATE AND OTHER BENEFITS SPECIFICALLY DESCRIBED HEREIN. THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

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GENERAL PROVISIONS

COVERAGE SUBJECT TO POLICY

The coverage described in this certificate is subject in every way to the terms of the policy that is issued to the policyholder. It alone makes up the agreement by which the insurance is provided. The group policy may be amended or discontinued by agreement between us and the policyholder in accordance with the terms of the policy. Your consent is not required for this. Neither are we required to give you prior notice.

ELIGIBILITY OF DEPENDENTS

Eligible dependents are the individuals defined as "Eligible Dependents" under the policyholder's Health and Welfare Plan.

Your dependents cannot be covered as both a dependent and as an associate with their own coverage. If your dependent is or becomes covered as an associate with their own coverage, we will terminate their coverage as a dependent and refund any premium that may have been paid for the dependent coverage for the period of time that they were covered as a dependent while having their own coverage.

A child born to you or your spouse, while Associate and Child(ren) Coverage or Family Coverage is in force, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for other dependent children covered under this certificate.

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If you have Associate-Only Coverage [or Associate and Spouse Coverage], newborn children are automatically covered from the moment of birth for a period of [60 days]. If you desire uninterrupted coverage for a newborn child, you must notify your employer within [60 days] of that child's birth. Upon notification to us, we will convert your Associate-Only Coverage to Associate and Child(ren) Coverage [or Associate and Spouse Coverage to Family Coverage] and provide notification of the additional premium due. If you do not notify your employer within [60 days] of the birth of the child, the temporary automatic coverage ends.

If you have Associate-Only Coverage or Associate and Child(ren) Coverage, then marry and desire coverage for your spouse, your employer must be notified within [60 days] of your marriage. We will convert your coverage to Associate and Spouse Coverage or Family Coverage and provide notification of the additional premium due.

An adopted child or child pending adoption will be covered as follows:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption has been entered into by you within [60 days] after the date of birth.
2. If adoption proceedings have been instituted by you within [60 days] after the date of birth and you have temporary custody, coverage is provided from the moment of birth.
3. For children other than newborns, if adoption proceedings have been completed, and a decree of adoption was entered within 1 year from the institution of the proceedings, coverage will begin upon temporary custody for 1 year, unless extended by the order of the court by reasons of the special needs of the child.

Coverage must be provided as long as you have custody of the child pursuant to decree of the court and required premiums are paid.

If you have Associate-Only Coverage [or Associate and Spouse Coverage], we will convert your Associate-Only Coverage to Associate and Children Coverage [or Associate and Spouse Coverage to Family Coverage] and provide notification of the additional premium due.

WHEN YOU CAN ENROLL OR CHANGE YOUR COVERAGE

You may apply for or change coverage as permitted under the terms of the policyholder's Health and Welfare Plan.

ELIGIBILITY DATE

If you are working for the policyholder in an eligible class, the date you are eligible for coverage is the later of:

1. the policy effective date; or
2. the date you become eligible for coverage under the terms of the policyholder's Health and Welfare Plan.

GENERAL PROVISIONS (Continued)

EFFECTIVE DATE OF COVERAGE

5

If you enrolled for this coverage provided by us during your employer's initial enrollment period during the [Fall of 2009], your coverage is effective on [January 1, 2010]. If you enrolled for coverage anytime after your employer's initial enrollment period or anytime on or after [January 1, 2010], your coverage will be effective in accordance with the terms of the policyholder's Health and Welfare Plan.

For any change in coverage, the change in coverage is effective in accordance with the terms of the policyholder's Health and Welfare Plan.

CERTIFICATE OF INSURANCE

This certificate of insurance provides a description of the insurance provided by the policy issued to your employer. It describes the essential features of the insurance coverage and to whom benefits are payable.

If there is any discrepancy between the provisions of this certificate and the provisions of the policy, the provisions of the policy govern.

TERMINATION OF COVERAGE

Your coverage under the policy ends subject to the "Portability Coverage" provision of this certificate on the earliest of:

1. the date the policy is canceled by the policyholder; or
2. the last day of the period for which you made any required premium payments; or
3. the last day you are in active employment, except as provided under the "Leave of Absence" provision; or
4. the date you are no longer in an eligible class; or
5. the date your class is no longer eligible.

We will provide coverage for a payable claim that occurs while you are covered under the policy.

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death, or when you move to an eligible class that does not provide spouse coverage.

Coverage for a dependent child ends on the certificate anniversary next following the date the child is no longer eligible for coverage under the terms of the policyholder's Health and Welfare Plan. Coverage does not terminate for an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon you for support and maintenance.

The child's coverage continues as long as your coverage remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished to us when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims incurred after termination will not be paid. There may be no refund due if you have Associate and Child(ren) Coverage or Family Coverage and you have other dependent children insured.

Coverage may be eligible for continuation as outlined in the "Portability Coverage" provision.

AGENCY

For purposes of the policy, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed our agent.

GENERAL PROVISIONS (Continued)

LEAVE OF ABSENCE

If you cease active employment because of a leave of absence while coverage is in force, you will have the opportunity to continue your coverage while you are away from active employment. Coverage will be in accordance with the terms of the policyholder's Health and Welfare Plan. This includes, but is not limited to how coverage is provided, how premiums are paid for during the absence and whether coverage is reinstated upon return to employment.

INCONTESTABILITY

After 2 years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim.

6 [DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of the policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of the policy, such determinations shall be final and conclusive.]

LEGAL ACTION

No legal action may be brought to obtain benefits under the policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 180 days from the time a decision on appeal regarding a claim for benefits under this certificate has been rendered. A lawsuit may not be filed after this 180 day period expires.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder documenting any clerical errors.

BENEFICIARY; CHANGE OF BENEFICIARY

If no beneficiary is named, we will pay any benefits due at the covered person's death in the following order:

- 7
1. [to you, if living; otherwise
 2. to your spouse, if living; otherwise
 3. to the covered person's children, in equal shares, if living; otherwise
 4. to the covered person's parents, in equal shares, if living; otherwise
 5. to the covered person's siblings, in equal shares, if living; otherwise
 6. to the covered person's estate].

Any change of beneficiary must be filed with the policyholder or at our home office. It will not take effect unless so filed, but if so filed, will take effect on the date you signed it. This will be true whether or not the covered person is living on the date it is filed. There will be no prejudice to us on account of any payment we make prior to its receipt by us at our home office.

8 [UNPAID PREMIUM; EXCESS PREMIUM

Upon the payment of a claim under this certificate, any premium owed by you in an individual capacity that is more than [60 days] past due may be deducted from the benefit amount payable to you or one of your eligible dependents. Any excess premium will be refunded to you.]

PORTABILITY COVERAGE

We will provide portability coverage, subject to these provisions.

Such coverage will be available for a covered person, if the following criteria are satisfied:

1. coverage under the policy terminates as described in the General Provision entitled "Termination of Coverage"; and
2. we receive a request for portability and payment of the first premium for the portability coverage not later than [60 days] after such termination.

No portability coverage will be provided for any person, if his or her insurance under the policy terminated due to his or her failure to make required premium payments.

PORTABILITY COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under the policy. Any change made to the policy after a covered person is insured under the portability coverage will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after a covered person's coverage under the policy terminates.

PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance of each month of coverage to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate for the first [36 months] of portability coverage is the rate in effect under the policy for active associates who have the same coverage. After the first [36 months], the premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least [31 days] before any change is to take effect.

GRACE PERIOD

The grace period, as defined, will apply to each certificate holder of portability coverage as if such covered person is the policyholder.

TERMINATION OF PORTABILITY COVERAGE

Insurance under this portability coverage will automatically end on the earliest of the following dates:

1. the date you again become eligible for insurance under the policy; or
2. the last day for which premiums have been paid, if the covered person fails to pay premiums when due, subject to the grace period; or
3. with respect to insurance for dependents:
 - a. the date your insurance terminates; or
 - b. the date your dependent ceases to be an eligible dependent as defined.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

TERMINATION OF THE POLICY

If the policy terminates, you and your covered dependents will be eligible to exercise the portability privilege on the termination date of the policy. Portability coverage may continue beyond the policy's termination date, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.

LIMITATIONS AND EXCLUSIONS

The policy does not cover any loss incurred by a covered person as a result of:

1. an injury that occurred as the result of an on-the-job accident, except as may be provided under the On- and Off-the-Job Accident Only Intensive Care Unit Benefit; or
2. injury incurred prior to the covered person's effective date of coverage subject to the Incontestability provision; or
3. any act of war whether or not declared, participation in a riot, insurrection or rebellion; or
4. suicide, or any attempt at suicide, whether sane or insane; or
5. any injury sustained while the covered person is under the influence of alcohol or any narcotic, unless administered upon the advice of a physician; or
- ~~6. hernia, including any complications due to hernia; or~~
7. dental or plastic surgery for cosmetic purposes except when such surgery is required to treat an injury or correct a disorder of normal bodily function that was caused by an injury; or
8. participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or
9. committing or attempting to commit an assault or felony; or
10. driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway.

Any injury incurred while a covered person is an active member of the Military; Naval; or Air Forces of any country or combination of countries is not covered. Upon notice and proof of service in such forces, we will return the pro-rata portion of the premium paid for any period of such service.

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BENEFIT INFORMATION

OFF-THE-JOB ACCIDENT ONLY BENEFITS

If, while the policy is in force, a covered person sustains an injury caused by an off-the-job accident which results in any of the losses stated in this "Benefit Information" provision, and is diagnosed by a physician, we pay the following benefits for such loss. ~~Unless otherwise specified, if a loss is eligible to be paid under more than one benefit, the highest eligible benefit will be paid.~~ Any loss not stated in this "Benefit Information" provision is not covered under the policy.

- A. Emergency Treatment:** We pay \$120 for you or your covered spouse and \$70 for a covered child for required medical treatment as a result of a covered accident. This benefit is payable for physician fees, x-rays, and emergency room services. Treatment must be received within 72 hours of the covered accident. This benefit is payable only once for any and all treatment that occurs during any 24-hour period, per covered person, per covered accident.
- B. Follow-Up Treatment:** We pay \$25 per follow-up visit when a covered person requires additional follow-up treatment after receiving emergency treatment for which a benefit is paid under Emergency Treatment (benefit A). Follow-up treatment must be administered by a physician in a physician's office or in a hospital on an outpatient basis. Follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital. This benefit is payable for one follow-up treatment per day for a maximum of 6 treatments, per covered person, per covered accident. This benefit is not payable for treatments for which the Physical Therapy benefit (benefit R) is paid.
- C. Initial Hospitalization:** We pay \$1,000 the first time a covered person is hospital confined for at least 24 hours for treatment as a result of an injury; or \$1,500 if the covered person is admitted directly to a hospital intensive care unit. Confinement must start within 30 days of the covered accident. This benefit is payable only once per continuous hospital or intensive care unit confinement, per calendar year, per covered person.
- D. Hospital Confinement:** We pay a daily benefit of \$200 for a continuous hospital confinement, up to 365 days per covered accident, when a covered person is hospital confined for at least 18 hours for treatment as a result of an injury. Confinement must start within 30 days of the covered accident. This benefit is not payable for days on which the Rehabilitation benefit (benefit S) is paid. This benefit is paid in addition to the Initial Hospitalization benefit (benefit C).
- E. Intensive Care Unit Confinement:** We pay a daily benefit of \$400, up to 15 days for any one accident, per covered person, when a covered person is confined in a hospital intensive care unit, as a result of an injury. This benefit is paid in addition to the Initial Hospitalization benefit (benefit C) and the Hospital Confinement benefit (benefit D). Confinement must start within 30 days of the covered accident.
- F. Dislocation:** We pay the benefit amount shown in the chart below when a covered person sustains a dislocation as a result of a covered accident. This benefit is payable for only the first dislocation of a joint. If a covered dislocation is reduced with local anesthesia or no anesthesia by a physician, we will pay 25% of the benefit amount shown in the chart below. This benefit is payable for a maximum of 2 covered dislocations per covered person, per covered accident. ~~If more than 2 dislocations occur during a covered accident, we will pay benefits for the 2 dislocations with the largest dollar amount benefits.~~

<u>Joint</u>	<u>Benefit Amount</u>
Hip	\$2,000
Collar bone	\$800
Knee or shoulder	\$500
Ankle or foot (excluding toes)	\$500
Lower jaw	\$500
Wrist or elbow	\$400
Toe or finger	\$100

BENEFIT INFORMATION (Continued)

OFF-THE-JOB ACCIDENT ONLY BENEFITS (Continued)

- G. Burns:** We pay the benefit amount shown in the chart below when a covered person sustains a burn as a result of an accident if treated by a physician within 72 hours after a covered accident. Injuries due to sunburn are not a covered benefit.

<u>Affected Area</u>	<u>Benefit Amount</u>	
	<u>2nd Degree</u>	<u>3rd Degree</u>
1 though 19 Less than 20 square centimeters of the body surface	\$100	\$200
More than 20 but less than 40 through 39 square centimeters of the body surface	\$200	\$500
More than 40 but less than 65 square centimeters of the body surface	\$400	\$1,000
More than 65 but less than 160 square centimeters of the body surface	\$600	\$3,000
More than 160 but less than 225 square centimeters of the body surface	\$800	\$7,000
More than 225 square centimeters of the body surface	\$1,000	\$10,000

If the proof of loss does not specify the size of the burn, the lowest benefit amount shown will be paid.

- H. Skin Grafts:** We pay 50% of the benefit amount paid under the Burns benefit (benefit G) if a covered person receives one or more skin grafts for a covered burn. This benefit is paid in addition to the Burns benefit (benefit G).
- I. Eye Injury:** We pay \$250 for surgical repair or \$50 for removal of a foreign body by a physician if a covered person sustains an eye injury as a result of a covered accident.

- J. Lacerations:** We pay the benefit amount shown in the chart below when a covered person receives treatment for lacerations within 72 hours after a covered accident.

<u>Laceration</u>	<u>Benefit Amount</u>
Laceration(s) not requiring sutures	\$25
Single laceration less than 5 centimeters	\$50
Laceration(s) at least 5 centimeters but not more than 15 centimeters (total of all lacerations)	\$200
Laceration(s) over 15 centimeters (total of all lacerations)	\$400

If the proof of loss does not specify the size of the laceration, the lowest benefit amount shown will be paid.

- K. Fractures:** We pay the benefit amount shown in the chart below when a covered person sustains a fracture corrected by open or closed repair as a result of a covered accident. This benefit is payable for no more than 2 fractures per covered person, per covered accident. **If more than 2 fractures occur during a covered accident, we will pay benefits for the 2 fractures with the largest dollar amount benefits.**

<u>Fracture</u>	<u>Benefit Amount</u>
Hip	\$2,000
Skull	
depressed	\$1,500
simple	\$500
Leg	\$1,000
Rib	\$1,000
Vertebrae (body of), pelvis (excluding coccyx), or sternum	\$1,000
Vertebral processes	\$1,000
Upper jaw, upper arm, or face (excluding nose)	\$600
Hand (excluding fingers)	\$500
Foot (excluding toes/heel)	\$500
Lower jaw	\$500
Nose, heel, or finger	\$500
Shoulder blade or forearm	\$500
Wrist, elbow, ankle, or kneecap	\$500
Coccyx	\$200
Toe	\$200

We pay 25% of the amounts shown for chip fractures or other fractures not corrected by open or closed repair.

BENEFIT INFORMATION (Continued)

OFF-THE-JOB ACCIDENT ONLY BENEFITS (Continued)

- L. Emergency Dental Services:** We pay the benefit amount shown in the chart below when a covered person receives dental services as a result of an injury. This benefit is payable for no more than one dental benefit per covered person, per covered accident.

<u>Dental Service</u>	<u>Benefit Amount</u>
Broken teeth repaired with crowns	\$150
Broken teeth resulting in extractions	\$50

- M. Coma:** We pay \$10,000 if a covered person is in a coma as a result of a covered accident.

- N. Brain Concussion:** We pay \$50 if a covered person sustains a concussion as a result of a covered accident.

- O. Paralysis:** We pay the benefit amount shown in the chart below if a covered person suffers from spinal cord injury received in a covered accident which results in a complete and total loss of use of 2 or more limbs. Paralysis must last 30 or more consecutive days and must be confirmed by a physician. This benefit is only payable once per covered person.

<u>Paralysis</u>	<u>Benefit Amount</u>
Quadriplegia (Paralysis of 4 limbs)	\$10,000
Paraplegia (Paralysis of lower 2 limbs)	\$5,000

- P. Surgical Procedures:** We pay the benefit amount shown in the chart below if a covered person requires a surgical procedure as a result of a covered accident. Two or more surgical procedures performed through the same incision or entry point are considered 1 operation; we pay the amount for the procedure with the largest dollar amount benefit. Surgery must be performed within 1 year of a covered accident. Miscellaneous surgery is surgery that requires general anesthesia and is not covered by any other specific surgery benefit listed below. The miscellaneous surgery benefit is payable only once per 24 hour period even though more than 1 surgery or procedure may be performed.

<u>Surgery</u>	<u>Benefit Amount</u>
Open abdominal (including exploratory laparotomy), cranial, hernia, or thoracic surgery	\$1,000
Ruptured discs	\$500
Tendons and/or ligaments	\$500
Torn knee cartilages	\$500
Torn rotator cuffs	\$500
Arthroscopy without surgical repair	\$250
Miscellaneous surgery	\$250

- Q. Major Diagnostic Exams:** We pay \$150 if a covered person requires one of the following exams as a result of a covered injury: CT (computerized tomography) scan; MRI (magnetic resonance imaging); or EEG (electroencephalogram). The exam must be performed in a hospital, a physician's office, or an ambulatory surgical center. This benefit is limited to 1 payment per calendar year, per covered person.

- R. Physical Therapy:** We pay \$25 per day for physical therapy if a covered person receives physical therapy as a result of a covered injury. Therapy must be prescribed by a physician and begin within 30 days of the covered accident or discharge from the hospital and be received within the first 6 months after the covered accident or discharge from the hospital. This benefit is payable for 1 treatment per day for a maximum of 10 treatments per covered accident, per covered person. This benefit is not payable for treatments which the Follow-Up Treatment benefit (benefit B) is paid.

- S. Rehabilitation:** We pay \$100 per day if a covered person is confined to a rehabilitation unit as a result of a covered accident, provided that the covered person has been confined to a hospital immediately prior to being transferred to the rehabilitation unit. This benefit is paid for each day a room charge is incurred, up to 30 days for each covered person per continuous period of rehabilitation unit confinement, for a maximum of 60 days per calendar year. This benefit is not payable for days in which the Hospital Confinement benefit (benefit D) is paid.

BENEFIT INFORMATION (Continued)

OFF-THE-JOB ACCIDENT ONLY BENEFITS (Continued)

- T. Appliances:** We pay \$100 if a covered person, as a result of a covered injury and upon the advice of a physician, requires the use of a medical appliance as an aid in personal locomotion or mobility. Covered medical appliances are: crutches; wheelchair; leg brace; back brace; and walker. This benefit is payable only once per covered person, per covered accident.
- U. Prosthesis:** We pay \$500 if a covered person requires a prosthetic device as a result of a covered injury. This benefit is not payable for hearing aids, wigs, or any dental aids including false teeth. This benefit is payable only once per covered person, per covered accident.
- V. Blood, Plasma and/or Platelets:** We pay \$100 if a covered person, as a result of a covered injury, requires blood, plasma, and/or platelets. This benefit is not payable for immunoglobulins and is payable only once per covered person, per covered accident.
- W. Ambulance:** We pay \$150 for ground ambulance or \$1,000 for air ambulance if a covered person requires ambulance transportation to a hospital or emergency center as a result of a covered injury. The ambulance transportation must occur within 72 hours of the covered accident. Service must be provided by a licensed professional ambulance company.
- X. Transportation:** We pay \$400 per round trip for treatment at a non-local hospital as the result of a covered accident. This benefit is payable for only the covered person for whom the treatment is prescribed, except that if the treatment is for a covered dependent child and travel by common carrier is necessary, we pay an additional \$400 per round trip for one of the dependent child's parents or legal guardians to travel with the child. A physician must prescribe the treatment. This benefit is payable for up to 3 round trips per calendar year, per covered person. This benefit is not payable for transportation by ambulance or air ambulance to the hospital.
- Y. Family Lodging:** We pay \$100 per night for one motel/hotel room for an immediate family member to accompany the covered person who requires non-local hospital confinement as a result of a covered accident. This benefit is payable for up to 30 days per covered accident, and only during the days the covered person is confined in the hospital.
- Z. Accidental Death and Dismemberment:** We pay the benefit amount shown in the chart below if death or dismemberment occurs as a result of an injury sustained in a covered accident within 90 days of such accident. If more than 1 dismemberment is sustained in any 1 accident, the total amount we will pay will not exceed the highest single benefit for accidental dismemberment. Benefits are payable only once for any covered accident. If death and dismemberment result from the same accident, only the Accidental Death benefit will be paid. This benefit is paid regardless of whether the dismembered body part is surgically reattached.

<u>Accidental Death</u>	<u>Common Carrier</u>	<u>Other Accidents</u>		
Insured Associate:	\$100,000	\$25,000		
Covered Spouse:	\$100,000	\$25,000		
Covered Child:	\$15,000	\$7,500		
	<u>Both arms and both legs</u>	<u>2 eyes, feet, hands, arms or legs</u>	<u>1 eye, foot, hand, arm or leg</u>	<u>1 or more fingers and/or 1 or more toes</u>
Insured Associate:	\$25,000	\$25,000	\$6,250	\$1,250
Covered Spouse:	\$25,000	\$25,000	\$6,250	\$1,250
Covered Child:	\$7,500	\$7,500	\$1,875	\$500

BENEFIT INFORMATION (Continued)

ON- AND OFF-THE-JOB ACCIDENT ONLY INTENSIVE CARE UNIT BENEFIT

- A. Intensive Care Unit:** We pay a daily benefit of \$600 when a covered person is confined to an intensive care unit for at least 18 hours as a result of an injury from a covered on-the-job accident. This benefit is payable for up to 15 days per covered person, per covered accident. Confinement must start within 30 days of the accident.
- B. Step-down Intensive Care Unit Confinement:** We pay a daily benefit of \$200 for an off-the-job accident or \$400 for an on-the-job accident when a covered person is confined to a step-down intensive care unit for at least 18 hours as a result of an injury sustained from a covered accident. This benefit is payable in addition to any Hospital Confinement benefit (benefit D) payable for a covered accident. This benefit is payable for up to 15 days per covered person, per covered accident.

WELLNESS BENEFIT

10 Wellness: We pay [\$75] per certificate year, for either you or one other covered person, when an eligible examination or test is performed, after your coverage has been in force for at least 12 months. The test must be performed under the supervision of or recommended by a physician, while coverage is in force, and a charge must be incurred. We will pay this benefit regardless of the result of the examination or test. The eligible wellness examinations and tests are:

1. [annual physical examination; and
2. dental examination; and
3. mammography; and
4. pap smear; and
5. eye examination; and
6. immunization; and
7. flexible sigmoidoscopy; and
8. PSA (prostate specific antigen – blood test for prostate cancer); and
9. ultrasound; and
10. blood screening].

[If you were insured by the prior accident policy offered through the policyholder's Health and Welfare Plan, the length of time your prior coverage was in effect will reduce the waiting period for receiving benefits under this wellness benefit.]

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CLAIM INFORMATION

NOTICE OF CLAIM

11 We encourage covered persons to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim must be given to us within 60 days after the occurrence or commencement of any loss covered by the policy, or as soon as reasonably possible. Notice given by, or on behalf of, a covered person or the beneficiary, to us at [PO Box 41488, Jacksonville FL 32203-1488], with the covered person's name and certificate number, is notice to us.

A claim form can be requested from us. If it is not received within 15 days of the request, notice of the claim may be sent to us by providing us a statement of the nature and extent of the loss.

FILING A CLAIM

12 [If a covered person's claim is denied, a notice will be sent within a reasonable time period, but not longer than 90 days from receipt of the claim. If we determine that an extension is necessary due to special circumstances, this time may be extended for an additional 90 days. The covered person will receive notice before the extension that indicates the special circumstances requiring the extension and the date by which we expect to render a determination.

If the claim is in part or wholly denied, the covered person will receive notice of an adverse benefit determination that will:

- state the specific reason(s) for the adverse benefit determination; and
- reference the specific policy provisions on which the determination is based; and
- describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary; and
- describe the policy's claims review procedures and the time limits applicable to such procedures, including a statement of the covered person's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.]

PROOF OF CLAIM

Written proof must be given to us within 90 days of each loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 15 months from the time specified unless the covered person is legally incapacitated.

COOPERATION OF BENEFICIARY

The beneficiary must reasonably cooperate during any investigation and/or adjudication of a claim. This includes the authorization for the release of medical records and other information.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have any covered person examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of contestability, where it is not forbidden by law.

PAYMENT OF CLAIMS

After receiving written proof of claim, we will pay all benefits then due under the policy and will make payment to you, unless you have assigned the benefit to someone else. Any amounts unpaid at your death may, at our option, be paid either to the named beneficiary or as described in the "Beneficiary; Change of Beneficiary" provision.

CLAIM INFORMATION (Continued)

ASSIGNMENT

An assignment of the coverage under the policy is not binding on us, unless:

1. it is a written request; and
2. it is received and recorded by us at our home office.

We are not responsible for the validity of any assignment. An assignment is subject to any payment we make or other action we take before we record the assignment. An assignment may not change the owner or beneficiary.

OVERPAID CLAIM

We have the right to recover any overpayments due to:

1. fraud; or
2. any error we make in processing a claim.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid.

CLAIM REVIEW

13

[A covered person will have 60 days from the receipt of an adverse benefit determination to file an appeal. Requests for appeals should be sent to [American Heritage Life Insurance Company, PO Box 41488, Jacksonville FL 32203-1488].

The covered person will have the opportunity to submit written comments, documents, or other information in support of the appeal, and the covered person will have access to all documents that are relevant to the claim.

The covered person will be notified of our benefit determination on review within a reasonable time, but not later than 60 days from receipt of the request for review. If we determine that an extension is necessary due to special circumstances, this time may be extended for an additional 60 days. The covered person will receive notice before the extension that indicates the special circumstances requiring the extension and the date by which we expect to render a determination.

If the claim is in part or wholly denied, the covered person will receive notice of an adverse benefit determination that will:

- state specific reason(s) of the adverse determination;
- reference specific policy provision(s) on which the benefit determination is based;
- state that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- describe any voluntary appeal procedures offered by the policy and the covered person's right to obtain information about such procedures; and
- include a statement regarding the covered person's right to bring an action under section 502(a) of ERISA.]

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GLOSSARY

Active Employment. Means that you are working for the employer for earnings that are paid regularly and are performing the material and substantial duties as assigned by your employer. You will be deemed to be in active employment on a day which is not one of the employer's scheduled work days only if actively employed on the preceding scheduled work day. Temporary and seasonal workers are excluded from coverage.

The location at which you perform work must be:

1. your employer's usual place of business; or
2. an alternative work site at the direction of your employer; or
3. a location to which your job requires you to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment.

Associate. Means a person who is: (1) a citizen or resident of the United States or one of its territories; and (2) in active employment with the employer named as the policyholder.

Associate-Only Coverage. Means coverage that includes only you, as defined.

Associate and Child(ren) Coverage. Means coverage that includes only you, as defined, and eligible children.

[Associate and Spouse Coverage. Means coverage that includes only you, as defined, and your spouse.]

Calendar Year. Means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

Certificate Year. Means a consecutive 12 month period beginning on the effective date of insurance for each insured associate.

Coma. Means a continuous state of profound unconsciousness which lasts 7 or more consecutive days as a result of a covered accident. A coma is characterized by an absence of spontaneous eye movements, response to painful stimuli and vocalization. The condition must require intubation for respiratory assistance. Medically induced comas are excluded.

Common Carrier. Means only the following: commercial airlines; passenger trains; inter-city buslines; trolleys; or boats. It does not include taxis; intra-city buslines or private charter planes.

Continuous Hospital Confinement. Means one continuous confinement or two or more hospital confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Covered Accident. Means a sudden, unforeseen and unexpected event which occurs without the covered person's intent which results in an injury to the covered person and for which benefits are payable.

Covered Person. Means any of the following:

1. any eligible family member (including you) named in the enrollment or evidence of insurability form and acceptable for coverage by us; or
2. any eligible dependent added after the effective date; or
3. a newborn child or adopted child subject to the "Eligibility of Dependents" provision.

Day. A 24 hour period.

Eligibility Waiting Period. Means the continuous period of time that you must be in active employment in an eligible class before you are eligible for coverage.

Employer. Means the individual, company or corporation where you are in active employment, and includes any division, subsidiary, or affiliated company named in the policy.

Family Coverage. Means coverage that includes you, as defined, and your eligible dependents.

GLOSSARY (Continued)

Fracture. Means a break in a bone that can be seen by X-ray and can be corrected by open (surgery) or closed (manipulative) repair.

14 Grace Period. Means a period of [60 days] following the premium due date during which premium payment may be made. While the associate is employed with the policyholder, the premiums will be paid by the policyholder through payroll deductions. The grace period only applies to the Associate during any portability period, when Associates will be required to pay the premiums directly to us.

Hospital. Means a legally operated institution with established facilities (either on its premises or available to the hospital on a contractual, pre-arranged basis and under the supervision of a staff of one or more duly licensed physicians), for the care and treatment of sick and injured persons for diagnosis, surgery, and 24 hour nursing service. Hospital does not include:

1. any institution which is mainly a rest home, nursing home, convalescent home, or home for the aged; or
2. any institution which is mainly for the care and treatment of alcoholics or drug addicts, or mental or nervous disorders.

Hospital Confined or Confinement. Means confinement as an inpatient in a hospital for which a room and board charge is made by the hospital. It does not include confinement for an observation room or a fractional part of a day.

Hospital Intensive Care Unit. Means a hospital area of special care, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds, or wards normally used for patient confinement. In addition, the unit must provide the following:

1. 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis; and
2. direction and/or supervision by a full-time physician director or a standing "intensive care" committee of the medical staff; and
3. special medical apparatus used to treat the critically ill.

Hospital Intensive Care Unit Confinement. Means 1 continuous confinement or 2 or more hospital intensive care unit confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Immediate Family Member. Means spouse, mother, father, child, step-child, adopted child.

Injury. Means a bodily injury caused directly by an accident, independent of sickness, disease, bodily infirmity, or any other cause, occurring on or after the effective date of coverage and while coverage is in force. See the Limitations and Exclusions section for injuries not covered by the policy.

Inpatient. Means a covered person who is a resident patient using the room and board facilities of a hospital.

Insured Associate. Means an associate who has: (1) fulfilled all eligibility requirements set forth in the policy and the policyholder's Health and Welfare Plan; and (2) properly completed and signed the enrollment, provided that the enrollment has been received by us.

Leave of Absence. Means you are absent from active employment for a period of time that has been agreed to in advance in writing by your current employer. Normal vacation time or any period of disability is not considered a leave of absence.

Non-local. Means more than 100 miles from the covered person's home or site of the accident.

Nurse. Means any one of the following who is not a member of the covered person's immediate family or employed by the hospital where the covered person is confined:

1. licensed practical nurse (L.P.N.); or
2. licensed vocational nurse (L.V.N.); or
3. graduate registered nurse (R.N.).

GLOSSARY (Continued)

Off-the-Job Accident. Means an accident that occurs while a covered person is not working at any job for pay or benefits.

On-the-Job Accident. Means an accident that occurs while a covered person is working at any job for pay or benefits.

Paralysis. Means spinal cord injuries received in a covered accident that result in complete and permanent loss of function of two or more limbs for a period of not less than 30 days. Paralysis must be confirmed by the attending physician.

Payable Claim. Means a claim for which we are liable under the terms of the policy.

Physician. Means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the state he or she practices in.

We will not recognize you, your spouse, children, parents, or siblings as a physician for a claim.

Policyholder. Means the legal entity to whom the policy is issued.

Rehabilitation Unit. Means a hospital area providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a physician who is knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

Step-down Intensive Care Unit. Means a hospital area of special care, which provides a level of medical care below the highest level of acute medical care available at the hospital, but above the level of medical care in a regular private or semiprivate room or ward. The facility is separate and apart from the surgical recovery room, other rooms, beds, or wards normally used for patient confinement. In addition, the unit must provide 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis.

Under the Influence. Means a condition as determined by the laws of the state in which the loss occurred.

We, Us and Our. Means American Heritage Life Insurance Company.

You, Your or Yours. Means the insured associate, as defined, who meets the eligibility requirements.

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[STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as division offices, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to annually furnish each participant with a copy of the summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people who operate your Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including the Employer or any other person, may fire or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request materials for the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. Generally, you must complete the appeals process before filing a law suit against the Plan. However, you should consult with your own legal counsel in determining when it is proper to file a law suit against the Plan.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest regional office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration publications hotline at (866) 444-3272 or by logging on to the Internet at www.dol.gov/ebsa.]

[ADMINISTRATIVE INFORMATION

16

Plan Year: January 1 through December 31

Plan Number: 501

Type of Plan: Welfare benefit plan

Type of Administration: The Plan allocates discretionary authority among Committees (or their delegates) concerning the administration, interpretation, and application of the Plan. The Plan also provides that discretionary authority over claims for benefits and appeals may be allocated to, among others, an insurance carrier of an insured benefit.

Plan Sponsor:

Wal-Mart Stores, Inc.
702 SW 8th Street
Bentonville, AR 72716

Plan Administrator/Named Fiduciary:

The Administrative Committee
Associates' Health and Welfare Plan
922 West Walnut, Ste. A
Rogers, AR 72756-3540
(479) 621-2058

Agent for Service of Legal Process:

Corporation Trust Company
1209 Orange Street
Corporation Trust Center
Wilmington, DE 19801
Legal process may also be served on the Plan Administrator or Trustee.

Plan Sponsor's EIN: 71-0415188

Funding: Contributions to the Plan may be made by Wal-Mart Stores, Inc. out of its general assets or through the Associates' Health and Welfare Plan Master Trust. Contributions also may be required by employees, in an amount determined by Wal-Mart Stores, Inc. in its discretion. All assets of the Plan, including Associate contributions and any dividends or earnings thereon, shall be available to pay any benefits provided under the Plan or expenses of the Plan, including insurance premiums.

Plan Trustee: JP Morgan Chase Bank, N.A.

Plan Documents: This document, together with the current version of the Associate Benefits Book, constitutes the summary plan description (SPD) for the accident coverage portion of the Plan. The SPD, together with the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan Wrap Document, are the Plan documents for the Plan.

Plan Amendment or Termination: Wal-Mart reserves the right to amend or terminate at any time and to any extent the SPD, including the Associate Benefits Book, and the Associates' Health and Welfare Plan Wrap Document. None of the benefits described in this Document can be orally amended. All oral statements and representations shall be without force or effect even if such statements and representations are made by the Plan Administrator, by a management Associate of the Company, or by any member of the applicable committees of the Plan. Only written statements by the applicable committee of the Plan shall bind the Plan.]



Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

**THIS IS A GROUP ACCIDENT CERTIFICATE WHICH ONLY PROVIDES BENEFITS FOR
OFF-THE-JOB ACCIDENTS AS DEFINED AND ON- AND OFF-THE-JOB ACCIDENT
INTENSIVE CARE UNIT BENEFIT AS DEFINED WITHIN THIS CERTIFICATE
AND OTHER BENEFITS SPECIFICALLY DESCRIBED HEREIN.
THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**

American Heritage Life Insurance Company (AHL) Variables for Group Voluntary Accident Policy Forms (GAPWM, et al)

This group policy will be available to issue to employer groups. The following explain the variables included in the policy. The numbers correspond to the number within the boxes in the left margin of the text. Many of the variables are at the request of a specific employer, Walmart, which has requested this coverage and to whom we intend to issue a policy, after approval, with an effective date of January 1, 2010.

1. The logo of the company will be on all policies and will be the current logo of AHL.
2. The signature of the Secretary and President will be on all policies issued and will be that of the current Secretary and President of AHL.
3. If any variable language is deleted for a specific policyholder, pages will be re-numbered accordingly and the Table of Contents updated for new page numbers.
4. The complete legal name of the policyholder will be inserted.
5. A unique alphanumeric number will be assigned to each group policy.
6. The effective date requested by the policyholder, and agreed to by AHL, will be inserted.
7. The policy anniversary date will be one year from the policy effective date.
8. The classes of employees who are eligible will be accurately described here.
9. The eligibility waiting period determined by the policyholder, if any, will be described here.
10. Rates may vary according to the currently approved rates for these plans.
11. AHL may guarantee the initial rate for a period no less than 12 months from the policy effective date, but the period can be longer based on our agreement with the policyholder.
12. The premium may be paid annually, semi-annually, quarterly, monthly, semi-monthly, bi-weekly or weekly. The first premium due date is the effective date of the policy.
13. This statement may vary, to indicate whether or not the employer shares in the cost of coverage under the policy.
14. Any of the policyholder's divisions, subsidiaries or affiliated companies whose employees are to be eligible for coverage under this policy will be named here.
15. The percent of change in item 2 will be the percentage taken into consideration when underwriting the group and determining the initial rate. The time period for notice of change in premium rate will not be less than 30 days, but may be longer if agreed to by us and the policyholder.
16. The time of notice of cancellation or offer to modify may be any period of 365 days or less if agreed to by us and the policyholder. The grace period will never be less than 31 days but could be more if agreed to by us and the policyholder. The time period for cancellation of the policy may be 30 days, but may be longer if agreed to by us and the policyholder. If the period for AHL to cancel or modify is more than 30 days, that same period will be entered here.
17. Newborn children will be covered for a minimum of 60 days from their date of birth, but this period may be longer or shorter if agreed to by us and the policyholder. Adopted children will be covered for a minimum of 60 days from their date of birth, but this period may be longer or shorter if agreed to by us and the policyholder. The time frame for notification of new dependents will never be less than 31 days, but may be more if agreed to by us and the policyholder.

18. The Grace Period will not be less than 31 days, but may be longer if agreed to by us and the policyholder.
19. Discretionary Authority may be removed if not governed by ERISA.
20. The order or inclusion of the listed persons may vary as requested by the policyholder.
21. This provision may be deleted in its entirety if the policyholder chooses not to include in their policy when issued.
22. The time frame for requesting Portability Coverage will be determined by the policyholder. The portability premium rate will not change for the first 36 months of portability coverage, or for a shorter period of time, but not less than 12 months, if agreed to by us and the policyholder. Written notice for such change will not be less than 31 days, but may be longer if agreed to by us and the policyholder.
23. The Wellness Benefit will be sold in units of \$25, from 1 unit of coverage up to 10 units. Any of the eligible tests may be deleted if the policyholder does not want to include in their policy. If the policyholder did not have a prior accident policy, the bracketed statement reducing the waiting period will be deleted.
24. The address for submitting claims will be our current address.
25. Procedures for filing a claim may be revised at the request of the policyholder or as required by changes in ERISA.
26. Procedures for review of a claim may be revised at the request of the policyholder or as required by changes in ERISA. The address for sending appeals will be our current address.
27. The Grace Period as described in item 18 of this Statement of Variability will be entered here.

Variables for Group Voluntary Accident Certificate Form (GACWM)

The variables in the certificate have the same explanation as the variables in the policy.

SERFF Tracking Number: ALST-126282608 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 43415
 Company Tracking Number: GVA WALMART
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Group Accident for Walmart
 Project Name/Number: /

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/01/2009	Form	Evidence of Insurability and Enrollment Form	09/16/2009	Walmart Enrollment and EOI Form Spanish.pdf (Superseded)
09/01/2009	Form	Evidence of Insurability and Enrollment Form	09/16/2009	Walmart Enrollment and EOI Form.pdf (Superseded)



Workplace Division

**AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224**

**WALMART [EVIDENCIA DE ASEGURABILIDAD (PRUEBA DE BUEN ESTADO DE SALUD)
Y] FORMULARIO DE INSCRIPCIÓN**

This box for AHL Home Office use only (Esta casilla es solo para uso de la oficina central de AHL)

Sírvase escribir en letra de imprenta con tinta negra

SECCIÓN DE INFORMACIÓN GENERAL
(Llene la sección completa)

NOMBRE DEL ASOCIADO Apellido (Sr., Jr., etc.) Nombre Inicial del segundo nombre		<input type="checkbox"/> H <input type="checkbox"/> M	NÚMERO DE SEGURO SOCIAL	ESTATURA	PESO	<input type="checkbox"/> Casado(a) <input type="checkbox"/> Soltero(a)
DIRECCIÓN PARTICULAR (Calle o casilla de correo)			CIUDAD	ESTADO	CÓDIGO POSTAL	
FECHA DE NACIMIENTO (MM/DD/AÑO)	NÚMERO DE TELÉFONO PARTICULAR	EMPLEADOR NÚMERO DE CASO WMART		FECHA DE CONTRATACIÓN (MM/DD/AÑO)		
OCUPACIÓN N/A	ESTADO SEDE AR	PLANTA O DIVISIÓN N/A	NÚMERO DE DOCUMENTO DE [WIN] IDENTIDAD DEL ASOCIADO			

SECCIÓN DE SELECCIÓN DE COBERTURA

Accidente <input type="checkbox"/> Sí <input type="checkbox"/> No	[<input type="checkbox"/> Asociado solamente <input type="checkbox"/> Asociado + Cónyuge <input type="checkbox"/> Asociado + Hijo(s) <input type="checkbox"/> Familiar]	<input type="checkbox"/> Elección nuevo <input type="checkbox"/> El cambio de elección de estatus _____ Razón del cambio _____ Fecha del evento _____
		<input type="checkbox"/> El cambio de elección de estatus _____ Razón para el cambio _____ Fecha del evento _____

Enfermedad grave <input type="checkbox"/> Sí <input type="checkbox"/> No Monto de beneficio básico \$ _____ <small>[Monto de emisión de garantía de \$5,000, \$10,000 o \$15,000. Se pueden elegir montos de \$20,000, \$25,000, \$30,000, \$40,000 o \$50,000, sujeto a prueba de buen estado de salud.]</small>	[<input type="checkbox"/> Asociado solamente <input type="checkbox"/> Asociado + Cónyuge <input type="checkbox"/> Asociado + Hijo(s) <input type="checkbox"/> Familiar]	<input type="checkbox"/> Elección nuevo <input type="checkbox"/> El cambio de elección de estatus _____ Razón para el cambio _____ Fecha del evento _____
		<input type="checkbox"/> El cambio de elección de estatus _____ Razón para el cambio _____ Fecha del evento _____

[SECCIÓN DE COBERTURA DE DEPENDIENTES

(Completar si se elige cobertura de dependientes. Use hojas adicionales de ser necesario).

Elija los planes:		Nombres de los dependientes (Apellido, nombre, inicial del segundo nombre)	Parentesco	Género	Fecha de nacimiento (MM/DD/AÑO)
Accidente	Enfermedad grave				

[SECCIÓN DEL BENEFICIARIO

(Seleccione su beneficiario. Use hojas adicionales de ser necesario).

Para los planes:		Nombre del beneficiario (Apellido, nombre, inicial del segundo nombre)	Parentesco	Edad	Primario, secundario o terciario	Asignación
Accidente	Enfermedad grave					
						%
						%
						%
						%

*Las asignaciones para beneficiarios primarios, secundario o terciario deben ser equivalentes al 100%.

**WALMART [EVIDENCIA DE ASEGURABILIDAD (PRUEBA DE BUEN ESTADO DE SALUD)
Y] FORMULARIO DE INSCRIPCIÓN**

[SECCIÓN DE PRUEBA DE BUEN ESTADO DE SALUD PARA ENFERMEDAD GRAVE

Inscripción inicial. Responda a cada pregunta en caso de solicitar un monto de beneficio básico de [\$20,000] o más.

Inscripción de incremento y posterior a la inicial Responda a cada pregunta en caso de solicitar un incremento de cobertura o en caso de solicitar la inscripción en algún momento posterior a su período inicial de inscripción.

Pregunta no médica			
1. ¿Se encuentra el asegurado propuesto trabajando activamente en la actualidad y ha trabajado cada semana realizando todas las actividades en su ocupación regular y en su lugar de empleo regular durante los últimos 3 meses, a excepción de enfermedades o lesiones menores con una duración de 1 semana o menos, licencia por un embarazo normal u otras licencias no relacionadas con su propia enfermedad o lesión?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	N/D	N/D
Preguntas médicas			
2. ¿A alguna persona propuesta para cobertura se le ha diagnosticado, tratado o se anticipa que será tratada por cualquiera de las siguientes: anemia drepanocítica; lupus; tuberculosis; síndrome de inmunodeficiencia adquirida por VIH (“SIDA”); complejo relacionado con el SIDA (AIDS related complex, “ARC”); enfermedad de Alzheimer; insuficiencia renal; enfisema; trastornos circulatorios; diabetes; epilepsia; cualquier forma de hepatitis; trastornos hepáticos; o cualquier trastorno de los riñones, la próstata, los pulmones y/o el páncreas?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No
3. ¿A alguna persona propuesta para cobertura se ha sometido o se le ha aconsejado realizarse un trasplante de órgano?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No
4. ¿A alguna persona propuesta para cobertura se le ha diagnosticado, tratado o aconsejado en los últimos 5 años por alguno de los siguientes: alcohol; drogadicción; asma; cualquier cáncer (excepto cáncer de piel de células basales) o cualquier otro tumor; cualquier afección cardíaca, ataque al corazón, accidente cerebrovascular, ataque isquémico transitorio (transient ischemic attack, TIA) o cualquier otra anomalía del corazón, incluida presión arterial alta con lecturas de 150 sistólica o 100 diastólica más de una vez durante el último año?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No

Inscripción inicial. Si el asociado responde “no” a la pregunta 1 o “sí” a las preguntas 2, 3 ó 4, emitiremos el monto de emisión garantizada de [\$15,000]. Si el cónyuge responde “sí” a las preguntas 2, 3 ó 4, el monto de beneficio básico del cónyuge es de [\$15,000]. Si cualquier hijo dependiente responde “sí” a las preguntas 2, 3 ó 4, a todos los hijos se les emite un monto de beneficio básico de [\$15,000].

Inscripción de incremento y posterior a la inicial Si usted responde “no” a la pregunta 1 o “sí” a las preguntas 2, 3 ó 4, usted no es elegible para la cobertura solicitada].

[NOTIFICACIÓN DE ENTREGA: Su certificado de seguro será puesto a disposición suya por parte de su empleador en forma electrónica. Junto con el certificado, habrá notificaciones legales y sobre privacidad. Para acceder a su certificado y a estas notificaciones legales, necesitará una computadora personal con conexión a Internet y un programa de navegación apropiado, y también el programa Adobe® Acrobat® Reader®. A menos que usted manifieste lo contrario a continuación, acepta recibir estas notificaciones legales con el certificado de seguro en forma electrónica por parte de su empleador. En cualquier momento, puede retirar su consentimiento y recibir una copia impresa de estas notificaciones legales llamando al 1-800-937-7039 o escribiendo a Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, FL 32224.

No acepto la entrega de las notificaciones legales por medios electrónicos. Sírvanse enviármelas por correo.]

[CERTIFICACIÓN, ENTENDIMIENTO Y AUTORIZACIONES

CERTIFICO que los enunciados y las respuestas provistos son efectuados por mí, son completos y verdaderos, han sido registrados correcta e íntegramente y que ninguna circunstancia o información importante ha sido retenida u omitida. Estos enunciados y respuestas se ofrecen a AHL a modo de inducción para la concesión de seguro, y entiendo que AHL podrá usar cualquier enunciado o declaración falsos para disputar la validez de cualquier cobertura provista sobre la base de esta Evidencia de Asegurabilidad (prueba de buen estado de salud) y Formulario de inscripción. • **AUTORIZO** a mi empleador a deducir de mi salario o sueldo la prima necesaria para las coberturas solicitadas. Entiendo que si rechazo cualquier cobertura para la cual soy elegible, se puede requerir prueba de asegurabilidad satisfactoria, por mi cuenta y cargo, en caso de que desee solicitarla en una fecha futura. Tal solicitud podría ser denegada sobre la base de dicha prueba.]

NOTIFICACIÓN SOBRE FRAUDE: Cualquier persona que, a sabiendas, presente un reclamación falsa o fraudulenta por el pago de una pérdida o beneficio o que, a sabiendas, presente información falsa en una solicitud de seguro será culpable de un crimen y podrá estar sujeta a multas y encarcelamiento.

Firma del asociado _____ Firmado en _____ Fecha de la firma _____
(Ciudad y estado)



AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Workplace Division

WALMART [EVIDENCE OF INSURABILITY (PROOF OF GOOD HEALTH) AND] ENROLLMENT FORM

This box for AHL Home Office use only

GENERAL INFORMATION SECTION
(Please complete entire section)

Please print with black ink

ASSOCIATE'S NAME Last (Sr, Jr, etc.)	First	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER	HEIGHT	WEIGHT	<input type="checkbox"/> Married <input type="checkbox"/> Single
RESIDENCE ADDRESS (Street or P.O. Box)				CITY	STATE	ZIP	
BIRTHDATE (MM/DD/YEAR)	RESIDENCE PHONE NUMBER	EMPLOYER CASE NUMBER WMART			DATE HIRED (MM/DD/YEAR)		
OCCUPATION N/A	SITUS STATE AR	PLANT OR DIVISION N/A		ASSOCIATE'S [WIN] ID NUMBER N/A			

SELECTION OF COVERAGE SECTION

Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Associate Only	<input type="checkbox"/> New Election
	<input type="checkbox"/> Associate+Child(ren)	<input type="checkbox"/> Status Change Election _____
	<input type="checkbox"/> Associate+Spouse	Reason for Change _____
	<input type="checkbox"/> Family]	Date of Event _____

Critical Illness <input type="checkbox"/> Yes <input type="checkbox"/> No Basic Benefit Amount \$ _____	<input type="checkbox"/> Associate Only	<input type="checkbox"/> New Election
	<input type="checkbox"/> Associate+Child(ren)	<input type="checkbox"/> Status Change Election _____
[Guarantee Issue Amount of \$5,000, \$10,000, or \$15,000. Amounts of \$20,000, \$25,000, \$30,000, \$40,000 or \$50,000 can be elected subject to proof of good health.]	<input type="checkbox"/> Associate+Spouse	Reason for Change _____
	<input type="checkbox"/> Family]	Date of Event _____

[DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Choose Plan(s):		Dependent's Name(s) (Last, First, M.I.)	Relationship	Gender	Date of Birth (MM/DD/YEAR)
Accident	Critical Illness				

[BENEFICIARY SECTION

(Please select your beneficiary. Use additional paper if needed.)

For Plan(s):		Name of Beneficiary (Last, First, M.I.)	Relationship	Age	Primary, Secondary or Tertiary	Allocation
Accident	Critical Illness					
						%
						%
						%
						%

*Allocations for Primary, Secondary and Tertiary Beneficiaries should equal 100%.

**WALMART [EVIDENCE OF INSURABILITY (PROOF OF GOOD HEALTH)
AND] ENROLLMENT FORM
[PROOF OF GOOD HEALTH SECTION FOR CRITICAL ILLNESS**

Initial Enrollment. Please answer each question if you are requesting a Basic Benefit Amount of [\$20,000] or more.

Increase And Post Initial Enrollment. Please answer each question if you are applying for an increase in coverage or if you are applying any time after your initial enrollment period.

Non-Medical Question			
1. Is the proposed insured actively at work now and has he/she worked each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, normal pregnancy or other leaves of absence that are not related to his/her own illness or injury?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	N/A
Medical Questions			
2. Has any person proposed for coverage been diagnosed, treated, or anticipate being treated for any of the following: Sickle Cell Anemia; Lupus; Tuberculosis; HIV Acquired Immune Deficiency Syndrome ("AIDS"); AIDS Related Complex ("ARC"); Alzheimer's Disease; Kidney Failure; Emphysema; Circulatory Disorders; Diabetes; Epilepsy; any form of Hepatitis; Liver Disorders; or any disorder of the Kidneys, Prostate, Lungs, and/or Pancreas?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has any person proposed for coverage had or been recommended to have an Organ Transplant?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any person proposed for coverage been diagnosed, treated for or counseled in the last 5 years for: Alcohol; Drug Abuse; Asthma; any Cancer (except basal cell skin cancer) or any Malignancy; any Heart Conditions, Heart Attack, Stroke, Transient Ischemic Attack (TIA), or any other abnormality of the Heart including High Blood Pressure with readings of 150 systolic or 100 diastolic more than once in the last year?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Initial Enrollment. If the associate answers "no" to Question 1 or "yes" to Questions 2, 3, or 4, we will issue the guaranteed issue amount of [\$15,000]. If the spouse answers "yes" to Questions 2, 3, or 4, the spouse's Basic Benefit Amount is [\$15,000]. If any dependent child answers "yes" to Questions 2, 3, or 4, all children are issued a Basic Benefit Amount of [\$15,000].

Increase And Post Initial Enrollment. If you answer "no" to Question 1 or "yes" to Questions 2, 3, or 4, you are not eligible for the requested coverage.]

[DELIVERY NOTICE: Your certificate of insurance will be made available to you by your employer in electronic form. Included with the certificate will be privacy and other legal notices. To access your certificate and these legal notices, you will need a personal computer with internet access and appropriate browser software, and Adobe® Acrobat® Reader® software. Unless you decline below, you agree to receive these legal notices with the certificate of insurance in electronic form provided by your employer. At any time, you may withdraw your consent and receive a paper copy of these legal notices by calling 1-800-514-9525; or by writing to American Heritage Life Insurance Company, PO BOX 41488, Jacksonville, FL 32203-1488.

I decline electronic delivery of the certificate and the legal notices. Please mail them to me.]

[CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

I CERTIFY that the statements and answers provided are made by me, are complete and true, are correctly and fully recorded and that no important circumstance or information has been withheld or omitted. These statements and answers are offered to AHL as an inducement to grant insurance, and I understand that AHL may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this Evidence of Insurability (Proof of Good Health) and Enrollment Form. · **I AUTHORIZE** my employer to deduct from my salary or wages the necessary premium for the coverage(s) requested. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.]

FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Associate's Signature _____ Signed at _____ Date Signed _____
(City and State)